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JOURNAL OF THE ROYAL COLLEGE OF NURSING

NURSING TIMES

Macmillan and Company, Limited, London — Saturday, July 3, 1954

EDITOR: MISS M. L. WENGER, S.R.N., S.C.M., DIPLOMA IN NURSING, UNIVERSITY OF LONDON

After Hospital . . .

AN important study published for the Nuffield Provincial Hospitals Trust under the title *Hospital and Community** draws attention to a disquieting situation. The study concerns over 700 unselected patients treated during 1950-1 in the men's medical wards of four 'acute' general hospitals in Stirlingshire and Ayrshire. It was undertaken by two expert authorities in the field of public health, in view of the continuing demand for the expansion of hospital care with its increasing costliness in money and highly skilled manpower, and in order to examine, within a necessarily limited area, how far the burden of hospital care is affected by social and environmental conditions.

With the help and encouragement of the four senior physicians in charge of the hospital wards in which the men were treated, and the co-operation of their family doctors, it was resolved to visit these patients, in their own homes, after an interval of two months and again after two years following their discharge from hospital. The results of this study confirmed the belief that so far as the area under review is concerned "the permanence of benefit derived from hospital treatment depends largely on the nature of conditions, at home and at work, to which the patient returns on leaving hospital", and that "further breakdown is sometimes precipitated by the transition—often sudden and dramatic—from the protective care of the modern medical ward to spartan conditions outside."

The reasons for these conclusions are clearly set out in the final chapter of this carefully compiled analysis, the whole of which merits close attention. The authors pay tribute to the work of earlier investigators which has a bearing on their own, notably to studies made in Oxford by Professor L. J. Witts and his co-workers, from which the necessity for "some form of social service, chiefly in connection with such problems as loss of wages, change of employment, and domestic difficulties" was established.

One-third of the 705 patients included in the study made by Professor Ferguson and Dr. MacPhail were found to have had hospital or outpatient treatment during the previous five years for the same condition or one closely related to it. It was estimated that 40 per cent. of them would be fit for work within three weeks of discharge. Visits made after three months showed, in fact, that though just over half were back at work, many of them were in danger of further breakdown because of unsuitable employment; a further 15 per cent. had died or were back in hospital; the rest were still unfit for work. At the end of two years almost a quarter of them had died and the condition of a further quarter was unimproved or had deteriorated.

The investigators point out that many of these patients were severely ill on admission to hospital and that "comparatively few suffered from conditions that lent themselves to complete cure." But they also suggest that in one quarter of the cases studied those conditions might have been prevented either on medical or social grounds. This suggests that the curative value of our present hospital service is sadly disproportionate to its cost in money and personnel and the investigators stress the need for improvement in social and environmental conditions if progress in recovery is to be maintained after hospital treatment.

The study revealed among other things that only four per cent. of the patients were given convalescent care before returning to their own homes; that about one-third of the men were unable, or unwilling, to follow the medical advice given that would have rendered them less likely to relapse; that unskilled labourers fared worse after leaving hospital than those from other occupational groups; and that of those who soon broke down again many did so because of bad social conditions.

It was also found that few of those who had been registered as disabled persons had received training in a new occupation, from which the authors gained the impression that lack of suitable training courses was a factor in helping to delay return to work. An interesting statistical appendix shows the employment position of the 474 men seen in their own homes 2 years after leaving hospital. Only 54 per cent. of them were fit for the work they had been doing before admission to hospital at the time the study was begun; of the remainder, 24.7 per cent. were classified as not fit for their old work but fit for other work and 21.3 per cent. were not fit for work under ordinary industrial conditions.

The authors recommend therefore that more attention should be paid to the development of resources to build up the patient's strength after illness, instancing the care provided at the Astley Ainslie Institution in Edinburgh. They refer to the need for more satisfactory home medical

* *'Hospital and Community' by T. Ferguson, Professor of Public Health, University of Glasgow, and A. N. MacPhail, Lecturer in Public Health, University of Glasgow, published for the Nuffield Provincial Hospitals Trust by Geoffrey Cumberlege, Oxford University Press. Price (in U.K. only), 9s. 6d.*

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supervision after discharge, quoting the experience of the Montefiore Hospital, New York, and of Syracuse University Hospital, where a study of discharged patients had shown that only one-third were receiving satisfactory supervision after discharge. They also recommended that " there should be firmer links between hospital and family doctor and between both and the official machinery for helping disabled people to obtain suitable work."

These recommendations have a familiar ring. They have appeared recently in many forms in these pages, in reports of numerous meetings and conferences. This study takes the discussion a stage further by forcing the question " What do we really want of our hospital service ? " The authors doubt " whether results substantially better than those presented in this report can be obtained with things as they are ", adding: " It is important to preserve all that is best in our hospital tradition; but equally important to try to view hospital care in a true perspective."

Evidence reaches us daily in press cuttings from all parts of the country of the need for a new approach to medical and nursing problems. The appropriate care of the elderly infirm; the continuing shortage of nursing recruits, particularly in the mental field; the need for ' recovery homes ' as an integral part of our hospitals—to which attention was directed in a recent issue of *The Lancet*: these are some of the problems which must be met and resolved if the National Health Service is not to become increasingly a sickness service. In meeting them the nursing profession has a vital part to play—and we await with interest the discussions to be reported in these columns following the meetings of the Royal College of Nursing which are taking place this week in London.

TOPICAL NOTES

Australian Memorial Fund—

THE AGENT-GENERAL FOR VICTORIA in London, the Hon. Sir John Lienhop, has announced details of a fellowship in nursing which is to be made available during 1955 to a British subject with at least 10 years' residence in the United Kingdom. A similar fellowship is being offered by the Fund in journalism, and two fellowships in university subjects where the applicants may nominate the field of study or research in which they wish to work. The British Memorial Fund has been established by citizens of the State of Victoria, Australia, as a " gesture of loyalty, gratitude and affection " to the British people in recognition of their " role in saving civilization in the Second World War." It offers each year a number of fellowships, tenable in Victoria, to graduates and young persons in the United Kingdom in the hope that they will return to their own country with a desire to strengthen the ties between it and Australia. The fellowship is for £1,000 (Australian) to cover travelling expenses to and from Melbourne and 10 months' living expenses in the State. The tenure would normally be for the academic year commencing March 1955, and candidates should be prepared to travel to Victoria during January 1955. Accommodation will be arranged for selected candidates. Applicants for the fellowship must be under the age of 35 on January 1, 1955.

—Nursing Fellowship

THE FELLOWSHIP IN NURSING is available to a State-registered nurse who, preferably, has had at least six years in the profession and, in addition, must have some post-graduate qualifications in any one of the various branches of the nursing profession. The fellow will work largely in association with the Australian College of Nursing and the Royal Victorian College of Nursing. Opportunities will be provided for attending post-graduate courses in such subjects as nursing administration; nurse teaching; general and midwifery nursing; ward administration; and theatre management and teaching. Full particulars may be obtained from the Hon. Sir John Lienhop, Victoria House, Melbourne Place, Strand, London, W.C.2, the closing date for the receipt of applications being August 2, 1954.

Royal Visitor on Rose Day

PRINCESS ALEXANDRA gave her personal interest and encouragement to the Alexandra Rose Day collectors in London on June 22. During her tour of the depots the Princess was welcomed at the Haymarket, allocated to the Educational Fund Appeal of the Royal College of Nursing, by a guard of honour of nurses who had volunteered as rose-sellers. Princess Alexandra was received by Lady Heald, chairman of the Appeal Council, Mrs. Stocken, Appeal Secretary, and the chairman and members of the Board of Messrs. Dewar's who had most kindly lent their boardroom for reception purposes and their premises for the depot. The one hundred nurses collecting for the College, who worked in relays to keep the sector manned, came from the following hospitals: Bethlem Royal, Brompton, Central Middlesex, Fulham, Hampstead General, King's College, Lewisham, North Middlesex, Royal Free, Royal National Orthopaedic, St. Charles', St. George's, Westminster, Whipps Cross. Miss S. E. Thomas (Fulham Hospital) and Miss Middleton (Royal National Orthopaedic Hospital) sold roses at Buckingham Palace, and took special roses for the Royal Family. They had the honour of being conducted to various departments of the Palace and then to the Royal nurseries, where the Duke of Cornwall and Princess Anne added their contributions and received their roses.

Left: *Princess Alexandra, looking charming in primrose yellow pleated shantung, talks to nurses who collected on Alexandra Rose Day.*

Right: *eight Swedish polio patients are making a 1,200-mile caravan tour of Britain. The party is seen with Mr. Donald Wade, M.P., vice-chairman of the British National Fund for Polio Research (which helped to organize their tour), after a conducted visit to the House of Commons.*

General Practice

A SURVEY of general practice under the Health Service (*Report of Committee on General Practice*, H.M. Stationery Office, price 2s. 6d. or post free 2s. 8d.) is contained in the report of a committee of the Central Health Services Council which, under the chairmanship of Sir Henry Cohen, was set up in December, 1950. The report does not call for revolutionary changes; it analyses most of the known problems connected with general practice and a total of over 60 conclusions and recommendations covers the range of a general practitioner's work. Among its conclusions and recommendations are that: general practitioners might with advantage try out an appointments system for their patients; a low standard of surgery and waiting-room accommodation cannot be justified and the time has now come to press for improvement, particularly in the case of some industrial practices; hospitals should aim to keep general practitioners informed of what happens to their patients in hospital. The committee stresses that the general practitioner service is an essential, not a subordinate service; indeed, in a sense, the general practitioner must hold the key position in the Health Service. The committee were pleased to note that greater efforts are now being made to associate more effectively the work of the general practitioner with that of the officers of local health authorities, and in particular with health visitors. The committee received much conflicting evidence on whether admission to the obstetric lists should be automatic as in Scotland, or subject to certain conditions as in England and Wales. It decided by a majority that there is value in the latter method. The committee suggests that the known need for co-operation between the three branches of the Service (hospital, general practitioner and local health authority) is, if sincerely faced, mainly a question of human attitude and behaviour.

Q.A.R.A.N.C. Association Reunion

A WELL-ATTENDED REUNION of Queen Alexandra's Royal Army Nursing Corps Association was held at the Hyde Park Hotel, Knightsbridge, London, S.W.1, on Saturday, June 19. Guests were received by Dame Louisa Wilkinson, D.B.E., R.R.C., Colonel Commandant, Q.A.R.A.N.C., and Brigadier Dame H. S. Gillespie, D.B.E., R.R.C., Q.H.N.S., Matron-in-Chief, Q.A.R.A.N.C. Lady Ampthill, as the guest of honour, presented the silver sports cup to Sergeant H. B. McIntyre. This cup is awarded annually to the officer or other rank who has contributed most during the year to the prestige of the Corps in the field of sport, the winner being selected by the various military units. This was the first occasion on which the other ranks had carried off the trophy, and Sergeant McIntyre received the congratulations of Lady Ampthill and the applause of the company as she was presented with the cup. Among those present at the reception were former Matrons-in-Chief, including Dame Katharine Jones, D.B.E., Dame Anne Thomson, D.B.E., R.R.C., also Lt.-Colonel P. Widger, R.R.C., chairman of the Q.A.R.A.N.C. Association. [See also page 718.]

The Lord Mayor of London, Sir Noel Bowater, the Lady Mayoress, Lord and Lady Luke, waiting to receive the guests at the Mansion House dinner in aid of the National Florence Nightingale Memorial Fund.

Florence Nightingale Memorial Dinner

HER Highness Princess Marie Louise, C.I., G.C.V.O., G.B.E., was the guest of honour at the dinner in aid of the National Florence Nightingale Memorial Fund held at The Mansion House, London, on June 24. The Rt. Hon. The Lord Mayor, Sir Noel Bowater, Bt., M.C., with the Lady Mayoress, The Rt. Hon. The Lord Luke, T.D., D.L., J.P., and Lady Luke received guests who numbered some 200. Among these were international dignitaries and representatives from a number of Embassies, the Minister of Health, the Rt. Hon. Iain Macleod, accompanied by Mrs. Macleod, Her Grace the Duchess of Marlborough, C.B.E., J.P., leading members of the nursing profession, many friends and supporters and a small group of Nightingale nurses in uniform, one of whom, Miss D. Gaffikin, most charmingly and ably proposed the concluding toast of the evening—that of The Lord Mayor and Lady Mayoress.

The guests were received under the glittering chandeliers of the anteroom, and dinner was served in the majestic Egyptian Hall, with its beautiful ceiling lit by concealed lighting, while the string orchestra of the R.A.M.C. played soft music in the gallery. Sir Noel Bowater proposed the loyal toast to the Queen and the toast to the Royal Family, and the Loving Cup tradition was observed.

Proposing the toast "The Florence Nightingale House" the Minister of Health spoke of the now unimaginable conditions 100 years ago which had been transformed by the Lady with the Lamp. Miss Nightingale was indeed tender, but she was also ruthless, sympathetic but also persistent, kindly but also having a will of iron; she was one of the great figures in history and through her struggle for what was good, she had altered the whole course of history. Her spirit lived on in the service given by nurses both in peace and in war. There were two ways, said Mr. Macleod, in which all could help to further that spirit—a belief in the things Miss Nightingale fought for 100 years ago and practical support for the house for international nurses studying in London—Florence Nightingale House.

Lord Luke, in reply, referred to the encouraging response already shown to the appeal and said that £3,500 (approximately) had been raised through the organization of the Florence Nightingale Commemoration Day, May 12. Lord Luke also spoke of the ceremony in 1908 when Miss Nightingale had been the first woman to be granted the Freedom of the City of London—an occasion attended by an uncle of the present Lord Mayor.

Proposing the toast to the Lord Mayor and Lady Mayoress, Miss Gaffikin, ward sister of the City of London Ward, St. Thomas' Hospital, referred to the long history of association between the City and the care of the sick. The present appeal for Florence Nightingale House, where trained nurses from all over the world could live together while studying in this country, would have been a project in line with Miss Nightingale's aim to train educated women who would, in turn, start schools of nursing all over the world, thus raising the standard of nursing care. Those who remembered the spirit at the former residence in Manchester Square, which had been destroyed through enemy action, realized the goodwill and lasting fellowship created which made a real centre for better understanding and the furtherance of world peace. The Lord Mayor, replying at first in light-hearted vein appropriate to midsummer's night, concluded by enjoining all to support this cause for a profession which was dear to the hearts of all, and deserved all encouragement and support.

XUM

Some Aspects of Rheumatism*

by T. N. FRASER, M.D., F.R.C.P., F.R.F.P.S.,
Physician, Rheumatism Unit, Killearn Hospital, Stirlingshire.

RHEUMATISM, using the word in its widest sense, is one of the most important unsolved problems in medicine and has aptly been described as Public Health Enemy No. 1. It can be divided broadly into three groups: (*a*) acute rheumatism or rheumatic fever; (*b*) articular rheumatism i. rheumatoid type, ii. osteo-arthritic type; (*c*) non-articular rheumatism i. muscular type, ii. neurotic type.

The fact that about one-seventh of the invalidism among the population insured under National Health Insurance in Great Britain is estimated to be due to rheumatism gives some idea of the magnitude of the problem. Statistics have shown that every year there are over 1,000,000 sufferers from rheumatism among the industrial population in England and Wales, and in Scotland 50,000 insured persons are incapacitated by the rheumatic diseases for an average period of 60 days. Although 80 per cent. of these are suffering from soft-tissue or non-articular rheumatism and are therefore considered less serious, there still remains a large number of patients with articular rheumatism who show varying degrees of permanent incapacity. The economic loss to England and Wales from this cause has been calculated at £40,000,000 a year.

Incidence and Occupation

What occupations are known to be associated with a high incidence of rheumatism? The Department of Health for Scotland issued a report on the chronic rheumatic diseases in 1945 in which it stated that each year rheumatic conditions incapacitate:

Men
1 in every 21 miners.
1 in every 29 general labourers.
1 in every 37 transport workers.
1 in every 39 metal workers (including iron and steel industries).

Women
1 in every 37 domestic workers (including char-women).
1 in every 37 agricultural and fishing workers.
1 in every 40 outdoor workers.
1 in every 43 transport workers.

The vast majority of these patients suffer from non-articular rheumatism. Vernon found a high incidence of rheumatism in the steel industry, especially among puddlers and steel-melters. According to Buckley, miners are very subject to fibrositis. In other words, it will be seen that industries in which employees are exposed to hard manual work, unnatural postures, fatigue, dampness and variations in temperature are associated with a greater incidence of rheumatism. It is obvious, therefore, as Tegner points out, that a lot could be done to reduce the morbidity rate of rheumatism in industry if more attention were paid to the elimination of these harmful factors by the introduction of more labour-saving devices to prevent fatigue and air-conditioning to control temperature and humidity.

Acute rheumatism or rheumatic fever, with its frequent cardiac involvement, is a problem in itself and one of the greatest magnitude, and will not be dealt with here. What of the two main forms of articular rheumatism—osteo-arthritis and rheumatoid arthritis? While constituting only about 10 per cent. of all cases of rheumatism, they present a very difficult problem because some permanent incapacity remains in a very large number of cases. Furthermore, in rheumatoid arthritis the possibility of a re-activation of the disease at some future date must be kept in mind.

* *Abstract of a lecture given at a study day of the Glasgow Group, Occupational Health Section, Royal College of Nursing.*

Osteoarthritis

Osteoarthritis is characterized by degeneration of articular cartilage and by the formation of bony outgrowths at the edges of the affected joints. It is said to be due to an exaggeration of the normal wear and tear in the joints and is usually a disease of older people. It is, however, sometimes seen in young people as the result of repeated micro-traumata at work, of faulty body mechanics or of postural defects—for example, scoliosis, deformity in a limb, etc. It is especially liable to develop in heavy manual workers and affects chiefly the weight-bearing joints, such as the hip, knee and spine. The symptoms form the triad of pain, stiffness and limitation of movement of the affected joints

The treatment of osteoarthritis consists of:

(*a*) general measures—rest for the affected joint, change of occupation; (*b*) analgesic drugs; (*c*) physiotherapy—short-wave diathermy, deep X-ray therapy, massage and postural exercises; (*d*) orthopaedic measures in advanced cases—arthroplasty, arthrodesis.

Although the disease is slowly progressive, the prognosis is much more favourable than in rheumatoid arthritis, as usually only one or two joints are involved. Moreover, as it occurs mainly in the older age-groups, when the tempo of life is of necessity decreasing and there is less physical stress and strain, any incapacity can be more patiently tolerated.

Rheumatoid Arthritis

Rheumatoid arthritis is a bilateral and symmetrical polyarthritis involving primarily the smaller joints. The cause of the disease is still unknown, but it is probable that several factors are responsible. Women are more frequently affected than men, the ratio being about three to one. Various aetiological and precipitating factors (such as heredity, infection, endocrine imbalance, physical and psychological stress and climatic conditions) have had their supporters, but none of these has gained general acceptance. Each or all of them may play a part in the aetiology of the disease, but it is obvious that there is a great need for further intensive research into aetiological problems. As to the pathology of rheumatoid arthritis, the brunt of the damage falls on the joints, where inflammatory changes may involve the synovial membrane, articular cartilage and underlying bone, according to the stage of the disease. The clinical picture of rheumatoid arthritis is so well known that it is unnecessary to mention it here, except to say that deformity and ankylosis of joints are often met with in the later stages of the disease.

Treatment of rheumatoid arthritis is of necessity empirical and will depend on the stage at which the disease is first seen. There are, however, two main aims in treatment: (i) the prevention of deformity, or its correction if it is already present; (ii) the maintenance of function.

In order to obtain the best results, the closest harmony must be maintained between the physician, orthopaedic surgeon, nursing staff, physiotherapist, occupational therapist and the almoner. All should work as a team and a course of treatment, planned to meet the needs of each patient, should be carefully worked out. It is hardly necessary to point out that without the co-operation of the patient treatment will be of little or no avail.

Treatment

Treatment can be discussed under five headings:

(1) **Medical.** Bed rest is advisable for those patients with involvement of the lower limbs. Some form of iron

should be given to correct the anaemia which is often present. Analgesics, such as aspirin, sodium salicylate or tab. codein co., will be required for the relief of pain, and at night a mild sedative may be necessary. Each year some new 'cure' is put on the market, only to be discarded in its turn. One drug, however, that has stood the test of time is gold. It is by no means a panacea, but it has a place in the treatment of rheumatoid arthritis.

In 1949, Hench and his colleagues in the Mayo Clinic were the first to report good results from the use of cortisone, a hormone, in rheumatoid arthritis. There is no doubt that it has a dramatic effect in suppressing the symptoms of the disease, but it is not curative and must be given for an indefinite period of time. Unfortunately, when the larger doses are continued for weeks or months undesirable side-effects are liable to develop in almost half of the patients. Moreover, owing to the high cost of cortisone its continued use is well beyond the means of the majority of people. To sum up, cortisone is of limited value in the treatment of rheumatoid arthritis and should not replace other well-established forms of therapy, but should take its place alongside them. The same criticisms apply to the use of the anterior pituitary hormone, ACTH. A drug which has come into prominence recently is Butazolidin; while it gives quite considerable relief from pain in about one case in four, its toxic effects are such as to make its general use undesirable.

(2) **Physiotherapy.** This is still our chief weapon in the treatment of rheumatoid arthritis and consists, in the main, of the use of heat, massage and exercises. There are various methods of applying heat, such as by paraffin wax baths, infra-red, radiant heat and short-wave diathermy. Exercises are of three varieties—passive, active non-weight-bearing and active weight-bearing. The importance of these, particularly the active variety, is only now being fully appreciated.

(3) **Orthopaedic Measures.** These include splinting, traction by weights, serial and wedge plasters, manipulation, and such operations as arthrodesis and arthroplasty. It is often necessary to splint an acutely inflamed joint, when it will be found that the symptoms of inflammation will subside more quickly. Furthermore, it is one certain method of relieving the pain in the affected joint. The risk of ankylosis occurring in the splinted joint has been overstressed in the past. For correction of deformity, such as a flexed knee, weight traction, serial or wedge plasters often give good results.

(4) **Occupational and Diversional Therapy.** The value of occupational therapy is twofold: it not only aids in the restoration of function of the affected joints, but also occupies the patient's mind, thus passing the time in an interesting and productive way.

(5) **Rehabilitation and Vocational Training.** As Tegner points out, rehabilitation should start from the moment the patient enters the hospital. The ultimate aim in treatment is to return the patient to his or her original employment, whether in industry or in the home. While many can resume where they left off, a large proportion of patients are unable to do so. It is for the latter that vocational training is so important. They should be trained, according to their functional capacity, to work at lighter jobs.

Unfortunately, there is a great lack of vocational training centres in this country. The Scandinavian countries are well ahead in this respect and have numerous institutions for this important aspect of rehabilitation. In Sweden it is hoped that before long specially equipped factories, shops and offices will be made available in the larger cities for those cripples who, even with selective employment, are unable to work in normal industry. The ultimate aim, too, is to bring work into the home from the different industries, such as sewing, knitting, etc., for home-bound individuals. It is obviously more economical for the community to have these people working. For the cripples themselves, to become useful members of the community once more and to be financially independent will give them a tremendous psychological uplift. Let us hope that the time is not so far distant when a scheme on similar lines will be set up in this country.

Case Study Competition: Highly Commended Entry.

DIABETIC PERIPHERAL NEUROPATHY

by CELIA JONES, Student Nurse, Manchester Royal Infirmary.

MRS. S. was admitted to a ward in Manchester Royal Infirmary on September 22, 1953. Mrs. S. was a tall, white-haired, very emaciated and prematurely aged lady of 61 years. She had at one time run a boarding house in Blackpool, but since the sudden death of her husband 18 months previously from coronary thrombosis at the age of 67, she had lived alone. She had no children. Mrs. S. was a particularly clean and neat patient; her personal hygiene was of a very high standard; her scanty, white hair was drawn back into a neat bun, and around her hunched shoulders was wrapped a crocheted bed-jacket—crocheting was an art in which she excelled.

History

Four years ago Mrs. S. had lost the use of her left foot for two months, and at this time no cause was ascertained. Eighteen months ago, on the sudden death of her husband, she noticed a marked loss of weight—about 3 st. over a relatively short period—and she became increasingly thirsty, experienced pruritus vulvae and polyuria. At approximately the same time she 'lost the use' of her right foot, which was followed by sensations of numbness and 'pins and needles' which were sufficiently severe to keep her awake, consequently she was admitted to a nursing home where sugar was found in her urine, and she was treated by diet and insulin. The irritation and thirst then improved, and she put on weight, but she complained of a steadily increasing constipation which persisted up to her admission here. The right leg improved at first, but about seven weeks before admission the condition of the left leg deteriorated, and she was bedridden.

On examination of the central nervous system the cranial nerves were found to be normal. Abnormalities were confined to the limbs:

Motor: in the arms the muscle bulk and power were normal for her age. In the legs there was severe wasting, more marked peripherally. There was considerable impairment of dorsiflexion of both feet.

Reflexes: there was complete areflexia.

Sensory: 'stocking' anaesthesia was discovered to all modalities of sensation.

The peripheral vascular system proved to be normal.

Diagnosis

Various investigations were carried out as an aid to diagnosis.

1. A glucose tolerance test showed an abnormally high fasting level of 260 mg./100 ml. with a delay of the fall of the blood sugar at the end of two-and-a-half hours.

2. A specimen of cerebro-spinal fluid was obtained and analysed—the only abnormality was the high protein level of 105 mg./100 ml.

3. A barium enema showed no radiological abnormality.

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4. A urea clearance test showed normal kidney function.
5. A full blood count was normal.
6. A Wasserman reaction proved negative.
7. Sweat testing of the feet showed paresis of the autonomic system.

The diagnosis was considered to be one of diabetes mellitus complicated by peripheral neuropathy, and this was considered to be a very severe case. The derangement of the autonomic system accounted for the bowel disturbance.

Immediate Treatment

On September 22 Mrs. S. began treatment on a 2,000-calorie diet, and soluble insulin, 14 units in the morning and 6 units in the evening. A course of Vitamin B was ordered in the form of Becosyn, 1 ampoule, and aneurine hydrochloride, 100 mg., to be given intramuscularly daily. Ascorbic acid, 100 mg., was also to be taken daily.

Mrs. S. was placed straightaway in bed and made comfortable. Because of the extreme burning pain experienced on skin stimulation in peripheral neuropathy, great care was taken with the patient's limbs. It was also seen that the paralysed muscles were not overstrained. Mrs. S. was provided with an air-ring, her limbs were elevated on a flock-pillow, and a bed-cradle with a wooden board attached was used to maintain the feet in the optimum position in an attempt to correct the foot-drop. Because of the impairment of the sympathetic nervous system the skin of the limbs and feet was dry and scaly, and bismuth and paraffin was used to massage the skin every four hours. Throughout her stay in the ward great care was exercised with regard to the whole skin surface of her legs and feet, and her pressure areas.

At this time Mrs. S. started to receive simple leg exercises. It was most important that this treatment should be both frequent and regular in order to keep the paralysed muscles in tone. She received actual instruction for half an hour daily, and practised on her own at various times for the rest of the day.

During the next fortnight she continued with this treatment and progressed satisfactorily. The strictest dietetic control was observed, and her diabetes proved easy to control. The amount of insulin previously ordered was sufficient to keep her blood-sugar within the normal range; no hypoglycaemic tendencies were noted. Her urine was tested four-hourly and no ketonuria developed.

October 8. Mrs. S. was provided with aluminium 'cock-up' splints for her feet which were removed four-hourly for the routine treatment of her pressure areas by washing and massage. She expressed her approval of their use and generally found them comfortable to wear. She was up for the first time on this day, and was naturally very pleased with herself. She was able to sit in a chair by the fire for about an hour.

October 17. During the night she complained of severe pain in both legs. Her splints were removed for a short period, and codein co., tabs. 2, was given with relief. She slept towards morning. Because of her somewhat unsettled night, Mrs. S. was loth to continue with her physiotherapy treatment in the morning. She appeared very distressed and despondent all day. During these attacks of depression which she had from time to time there was little we could do to encourage her. She seemed to dwell on her loneliness and illness to an exaggerated degree; the moods were a symptom of her diabetes, and at such times the assistance and co-operation of the resident chaplain were greatly appreciated.

Colonic Disturbance

November 5. Colonic disturbance had taken the form of increasing constipation both before admission and up to this date, and it now developed into neuropathic diarrhoea. Mrs. S. was given mistura creta et opii, ½ oz. three times a day, with no marked relief.

November 13. Sulphaguanidine, 2 g. six-hourly, was tried for three days. There was some slight relief. Mrs. S. was much more cheerful today, and stood up unaided. She was obviously much stronger and took up her crocheting again, which she had discarded a few days previously when the discomfort was so intense.

November 17. Mrs. S. was very distressed about her diarrhoea. She had otherwise been progressing favourably up to now. The diarrhoea was much more severe in character; it was not entirely nocturnal and varied from day to day. The treatment was changed to ephedrine, gr. ½ three times a day. With this treatment there seemed to be some improvement of the diarrhoea, and Mrs. S. became much more cheerful and took to her physiotherapy treatment with renewed vigour.

Progress

November 30. The diarrhoea was still persisting, but there seemed to be a general improvement in her condition. Mrs. S. took her first steps and was able to walk round her bed with assistance. The knowledge that there was some definite evidence of progress encouraged her tremendously. A course of intra-muscular Cytamen, 1,000 mg., was begun. There was a definite return of dorsiflexion of the feet, and the sensory changes in the limbs were less marked. Her own shoes were specially adapted with leather straps to fasten round the waist, and toe springs, in order to support the feet. She soon became used to them, and wore them whenever out of bed; she continued to wear the aluminium splints in bed.

December 17. Mrs. S. walked quite well. She became adept with her special shoes. The diarrhoea, though still present, appeared to be clearing up. She had only one complaint—the diet kitchen provided too much chicken for her supper!

December 22. Mrs. S. was discharged to be admitted to a nursing home for a short period during which her present treatment was to be maintained, that is, she was to continue on a 2,000-calorie diet and insulin, 14 units in the morning and 6 units in the evening. She was to receive regular physiotherapy treatment and intra-muscular injections of Cytamen, 1,000 mg.

During her period in hospital, we had seen her progress from a helpless, weak and bedridden invalid into a considerably more healthy and active person. She could now walk with some assistance. The severe diarrhoea which had been a complication of her illness and which had proved so obstinate to treat was at the time of her discharge much improved, and she was well on the way to recovery. Though sorry to leave the friends she had made in the ward over the past three months, Mrs. S. was much more cheerful and bright, and was looking forward to the future eagerly.

[This case study is written by permission of Dr. G. G. E. Smyth, and I would like to acknowledge the help of Dr. E. C. Hutchinson who assisted me in obtaining the patient's history.]

Seventh World Health Assembly

ADDRESSING the seventh World Health Assembly on May 5, Dr. G. M. Candau, Director-General, World Health Organization, said: "No one can build on shifting sands, and the first requirement is to enable member countries when needed, to establish their national health services on sound foundations, and one of the essential factors is the training of health personnel." They had to make certain, Dr. Candau continued, that in assisting countries who needed it the work would be completed and carried on by the government whose request for aid had been met, and that the money and energy invested should not be lost or wasted. WHO should do all possible to improve environmental sanitation everywhere, and again the principal problem was the training of competent personnel. Another important field of activity was to stimulate mass campaigns against endemic diseases, such as malaria, smallpox, yaws and typhoid, or against bilharziasis or trachoma. Dr. Candau said that there was no doubt that member countries were now convinced that it was in their own interest to consider the interests of all.

NURSE ASSIGNMENT

at St. James' Hospital, Balham

THE difficulties of nursing patients and training student nurses at one and the same time are great, but not insuperable. The most characteristic feature of student nurse training in this country is, perhaps, the early acceptance of personal responsibility, under supervision, for the care of patients. But closely linked with this is the amount of work which must be carried out adequately within 24 hours of every day, in spite of limited numbers of staff in which are included the nurses in various stages of training. The two patterns of ward methods which have developed can be, in the main, described as *patient assignment*, where each nurse is responsible primarily for certain patients; and *job assignment*, where the nurses are expected to cover tasks which may apply to all the patients in the ward—or to none in particular, if the tasks are of the more domestic nature such as attention to sterilizers or toilet equipment.

A number of hospitals have practised patient assignment in the training of nurses for many years. Many have modified it to enable the total work of the ward to be carried out by the minimum of staff. Others have never attempted it, on the grounds that more staff (not necessarily nurses) are needed and are not available. St. James' Hospital, Balham, is taking part, in certain wards, in the more recent introduction of the method of training by group assignment—that is, a group or team of nursing and auxiliary staff care for a group of patients (we hope to report on this more fully later). The hospital has also introduced in other wards the patient assignment method so that a comparative study of the various methods can be made. Below is the scheme introduced in ward 23, after full consultation.

The Ward Plan

Ward 23, a men's medical ward of 22 beds (not infrequently with several additional beds down the centre), is staffed by the ward sister, Miss J. Grundy, S.R.N., B.T.A. Cert., with a staff nurse (or two part-time staff nurses) a senior student nurse (third year) and two junior student nurses, with a relief nurse for days off. There are two full-time ward orderlies and one full-time domestic who deals with the cleaning of the ward and the washing-up. Each student nurse is assigned six patients and remains responsible for their personal care throughout; at the same time she undertakes certain administration duties. The most junior works with sister or the staff nurse and the two more senior work together. The following gives an outline of the scheme.

Staff Nurse

Responsible for the care of the patients in beds 1-3 and one in the side ward. On duty 7 a.m. Commence breakfasts. Take report from sister. Wash own patients, make their beds, take four-hourly temperatures and fill in charts. Carry out all treatment and leave patient comfortable and tidy. In addition her administrative duties include ordering dressings, supplies from laboratory, gas cylinders, responsibility for poison and D.D.A. cupboards and syringes.

Third-year Student Nurse

Responsible for patients in beds 16-21; care of patients as above. Administrative duties are: care of medicine, rectal and throat trays, blood trays, treatment and medicine cupboards, diagnostic cupboard; the ordering of linen

Above: *the doctor takes a specimen of blood; the patient has been prepared by the male student nurse responsible, who is releasing the tourniquet, and who prepared and will clear away the equipment required.*
Below: *a patient who is required to lie flat can enjoy a blanket bath skilfully carried out by the senior student nurse responsible assisted by a junior (right).*

Above: *the doctor reads the cerebro-spinal fluid pressure during a lumbar puncture. The senior student nurse responsible has prepared the equipment and holds the sterile receiver for a specimen of the fluid. The junior student nurse looks on and reassures the patient.*

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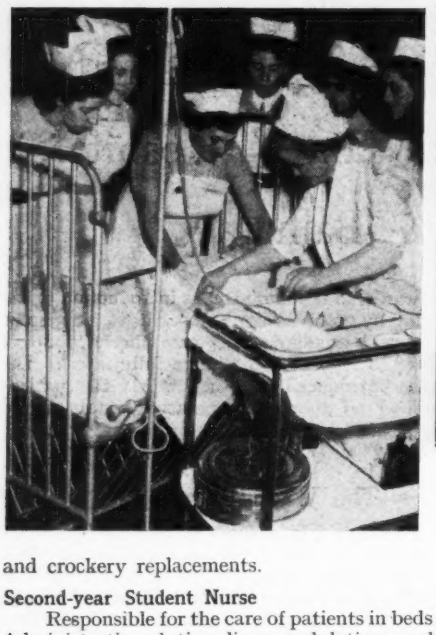

Above: *physician, patient and nurses from two wards enjoy the clinical teaching round held in the ward one morning each week; the ward sister is on the right.* Left: *in the classroom subcutaneous infusion for an infant is demonstrated on the doll.*

and crockery replacements.

Second-year Student Nurse

Responsible for the care of patients in beds 4-9 (as above). Administrative duties: linen and lotion cupboards, instruments, urine testing cabinet and ordering of dry stores.

First-year Student Nurse

Responsible for the care of patients in beds 10-15, working with sister (as above). Responsible for pressure areas treatment tray, washing of marked crockery, cleaning of sterilizers and sterilizing room and enamel ware. Administrative duties: filling in diet sheets and ordering stationery.

Relief Nurse

Carries out duties of nurse who is off duty.

Evening Work

The senior nurse on duty in the evening is responsible for the tidiness of the ward, the junior nurse being responsible for the tidiness of the sluice and bathroom.

Each nurse is responsible for her own patients' welfare during the day. Baths must be given at least twice weekly, charts must be kept up to date, and each nurse is responsible for all her patients' treatment and for reporting special fluids and drugs when going off duty. Patients requiring care by two nurses must be reported to sister. Each nurse is responsible for clearing away her trolleys after use.

Night Nurses

Work during night as usual. Responsible for preparing dressings, packing of drums and dispensary basket. **Senior Nurse.** Responsible for 6 a.m. treatment, temperatures of patients on twice daily charts, collecting, testing and recording urine of new patients (all other patients' urine is tested once a week) and for taking temperatures. **Junior Nurse.** Responsible for calling patients with tea at 6 a.m., giving out bedpans, collecting all cups, glasses, jugs, etc., preparing breakfast trolley and lighting oven and putting in plates. Both nurses make beds of patients who get up to wash. Give report to sister at 7.30 a.m.

* * * *

Ward 23 may be considered a typical medical ward with all the modern methods of medical treatment and diagnostic tests constantly being used. The following list will give an indication of some of the patients' conditions and treatment recently. Tuberculous meningitis now recovering, on daily PAS and isoniazid and having weekly lumbar puncture; lymphosarcoma, admitted acutely ill with pneumonia and deviated trachea; mitral stenosis with incipient cardiac failure (a young man); emphysema; acute rheumatism; broncho-pneumonia with low haemoglobin having tests for occult blood in stools; hypertensive heart failure; thrombosis of vein in the calf; subarachnoid haemorrhage recovering; malignant hypertension; hypertensive renal failure undergoing Amytal sedation test; muscle-wasting and twitching undergoing neurological investigation; cerebral embolism with mild degree of left hemiplegia; asthma; partial spontaneous pneumothorax (a youth of 18); periarteritis nodosum treated with ACTH; angina and obesity; pulmonary tuberculosis (in the side ward); an unconscious patient, subarachnoid haemorrhage.

In addition to the quiet, orderly and efficient management of all the routine work of such a ward, the doctors must be investigating, diagnosing and treating the patients and medical teaching rounds are held. A clinical teaching round for the nurses is given each week by the physician and any new treatments being carried out are shown to the student nurses. There is close liaison between ward sisters and sister tutors so that teaching is complementary and not diverse.

In this patient assignment scheme—or nurse assignment as it might be called—the student nurses can rightly say 'my patient', and the patient looks to 'his nurse', surely the first essential in good nursing.

Below: *a candidate seeking to enter the training school at St. James' Hospital, Balham, is interviewed by one of the tutors as well as by the matron. She will also take a 50-minute educational test designed for assessment of her basic knowledge of English and arithmetic, accuracy and style.*

BOOK REVIEWS

Expert Committee on Poliomyelitis

First Report.—*World Health Organization, Technical Report Series, No. 81. (Obtainable from H.M. Stationery Office, Kingsway, London, W.C.2, 3s. 6d.)*

This is a concise report on the present position of our knowledge of poliomyelitis with special reference to the epidemiology and control measures. The cover draws attention to the fact that the report contains the collective views of an international group of experts and does not necessarily represent the decisions or the stated policy of the World Health Organization.

The clinical picture is dealt with only very briefly and there is no mention of treatment. The simple measures in which the public should be instructed in an epidemic are essentially practical and should be widely understood. In contrast, as is to be expected in a disease whose spread is not fully understood, the measures suggested to prevent spread from the patient or his intimate contacts are stringent.

The uses and limitations of passive immunization by gamma globulin are explained and the report stresses that gamma globulin is scarce, and that further experience is required to estimate the best methods of using the available supplies. A section of the report deals with the technique of tissue culture, which has led to the greater ease of growing the virus where previously it was difficult to grow except in monkeys. Easier methods of cultivation have made possible the preparation of vaccines in which great hopes are placed for the future but which are still only in the experimental stage and will require years of trial to evaluate the results.

The report concludes with a short summary and recommendations for future research.

For the advanced student of poliomyelitis this is a stimulating report which brings very forcibly to the reader the many outstanding problems which yet require to be solved before the disease can be mastered.

F. L. K., M.B., Ch.B.

Mother and Baby Care in Pictures

(fourth edition)—*by Louise Zabriskie, R.N. (J. B. Lippincott Company, 10-13, Bedford Street, London, W.C.2, 24s.)*

In its fourth edition this book has been thoroughly revised and reset. The section on antenatal care particularly has been entirely replanned to include material on nutrition and natural childbirth, and much more expanded information on all aspects of the care of the mother and of the baby. The book is intended specifically for parents, and the author presupposes an American social background in her descriptions and recommendations. However, much of the text is applicable to all mothers and babies.

The book is very profusely illustrated (255 illustrations and 11 tables). One is inclined to regard some of these photographs as quite superfluous, serving no obvious purpose. What point is there for example in publishing photographs showing an expectant mother setting out for a walk with two male companions; an expectant mother walking in a busy city street (advertising the good effects of fresh air and sunshine); an expectant mother playing cards? There are many good diagrams though, and the excellent illustrations from the Dickinson-Belskie Birth Atlas Series are used to great advantage.

Detailed descriptions of preparations for a home delivery are included, as the author in her preface states that more than 600,000 home deliveries still take place yearly in the United States. Some techniques recommended here under the care of the baby would, I think, meet with disagreement in this country; for instance, cleaning the baby's nose and ears with cotton wool swabs on sticks; retracting the foreskin daily in a baby boy; separating the labia and swabbing the mucous membrane in a baby girl.

An interesting section, seldom found in any obstetric book, lay or medical, deals with the development of the baby's muscular control, mental powers and special senses of sight, touch, hearing, taste and smell during the first few months of life. This is informative and particularly valuable to inexperienced parents who probably tend to overestimate a baby's capacity to see, hear and smell. The book is attractively produced, and could be recommended to parents where the price is no deterrent.

J. H. O., S.R.N., S.C.M., Diploma in Nursing, University of London.

The Story of Nursing

—*by Jean McKinlay Calder, M.B.E., S.R.N. (Methuen and Co. Limited, 36, Essex Street, London, W.C.2, 8s. 6d.)*

In this book the author gives a comprehensive outline of the history of nursing from antiquity, through the ages to the modern era. From the time medicine branched off from magic and witchcraft in ancient Egyptian history, nursing is shown to be closely related to medical progress and practice.

The story continues through ancient Greece, where the foundations of scientific medicine were laid, to the history of pagan and Christian Rome with its progress in the science of public hygiene; it was here that the first chronicles of nursing began and with the deaconesses bringing nursing to a higher plane the compassionate care of the sick became a sacred obligation.

In the period of the Middle Ages with the development of hospitals and monasteries and the formation of the regular orders of nursing, it is realized how greatly nursing and provision for the sick was influenced by men and by the powerful force of monasticism.

The decline of nursing, arising from the dissolution of the monasteries, was followed by the development of post-reformation hospitals and the age of women pioneers of nursing reform; it was then that the creation of the educated nurse—the essence of Miss Nightingale's scheme of training—became a reality.

The author writes of the growth and widening scope of modern nursing, with its world-wide activity, the improved social conditions and the rich accomplishments in medical science since the turn of the century. The International Code of Nursing Ethics, adopted by the Grand Council of the International Council of Nurses in Brazil in July 1953, brings the story to an end and marks yet another milestone in nursing history.

The author is to be congratulated on the clarity, the mine of information for a book of this size and the sustained interest throughout the story. Intending nurses will find it gives a useful, adequate and accurate outline of the history of nursing, and the book should be a welcome addition to school book-shelves and libraries.

M. B. A., S.R.N., S.C.M.

Textbook of Medicine

(eleventh edition) *edited by Sir John Conybeare, K.B.E., M.C., F.R.C.P. and Dr. W. N. Mann, F.R.C.P. (E. and S. Livingstone Limited, 16-17, Teviot Place, Edinburgh, 37s. 6d.)*

Conybeare's *Textbook of Medicine* has become almost a household word in English medical schools and, indeed, the editors remark that it has been in existence for nearly a quarter of a century. This alone speaks highly in its favour, and there is no doubt it can still hold its own against its old and newer rivals.

The days when an author was able to write a complete textbook of general medicine unaided are almost over, and in this book there are 18 contributors, of whom seven are on the staff at Guy's. Better than many such books, however, is the way the many sections are skilfully integrated, giving the pleasant feeling that one is reading a book rather than a collection of articles.

'Conybeare's' has never set out to be a massive, comprehensive textbook to be consulted on obscure problems, and it still retains its relatively moderate size, giving the salient features of disease, and more than enough to enable a student to pass in medicine. It makes therefore a very good textbook to which student nurses and ward sisters may

turn, while it will certainly retain the affections of many medical students.

It has been brought thoroughly up-to-date; it includes excellent X-ray reproductions and has sections on psychological medicine and diseases of the skin. A small but very helpful feature is that at the beginning of the book are listed the normal figures for the common constituents of the blood, cerebro-spinal fluid, urine and faeces.

V. E. L. H., M.R.C.P.

Books Received

Mental Health and Human Relations in Industry.—*edited by T. M. Ling, M.A., D.M. (Oxon.), M.R.C.P., with a foreword by the Rt. Hon. Lord Horder, G.C.V.O., M.D., F.R.C.P. (H. K. Lewis and Co. Ltd., 21s.)*

The Art, Science and Spirit of Nursing.—*by Alice L. Price, R.N., M.A. (W. B. Saunders Co., 27s. 6d.)*

On Keeping Fit.—*by Mary Kidd, M.B. (Lond.), with a preface by C. C. Martindale, S. J. (Burns Oates and Washbourne, Ltd., 2s. 6d.)*

Young Nurse Carter; A Mary Dunn Career Novel.—*by Shirley Darbyshire. (Chatto and Windus, 7s. 6d.)*

Commonwealth Ties

PRESIDING at the 35th annual general meeting of the Society for the Oversea Settlement of British Women, on June 9, the Countess of Bessborough spoke of the vital usefulness, in strengthening mutual ties, of migration within the Commonwealth countries. Mrs. F. R. Phillips, chairman of the executive committee, spoke of the increased demand for trained social workers and nurses; over half the total number of the latter having gone out to Southern Rhodesia. Sir Thomas White, K.B.E., D.F.C., V.D., High Commissioner for the Commonwealth of Australia, in a most interesting talk on the opportunities which that country offers to new settlers, spoke of its size as being equal to that of the United States of America, with a population of two people to the square mile in contrast to 700 in Great Britain. Australia had no unemployment and an abundance of foodstuffs, wool and wheat; her immigration scheme offered opportunity for a cross-section of age groups, with assisted passages for successful applicants. A number of questions were then put to him about health and welfare services and housing conditions to which the replies showed that Australia was making considerable provision towards social security.

A DAY HOSPITAL FOR THE AGED SICK

at Cowley Road Hospital, Oxford

FOR those who are in daily contact with the desperate and almost unrelieved need of the aged sick, any new approach comes as a bright ray of hope. For this reason the experiment introduced a year or so ago in Oxford at the Cowley Road Hospital, the geriatric unit of the United Oxford Hospitals, under the inspiration of Dr. L. Z. Cosin, clinical director, is to be welcomed.

Cowley Road Hospital, built originally as a Poor Law institution, provides beds for 250 chronic sick patients and is a training school for assistant nurses. It has the services of an almoner's department, physiotherapy and occupational therapy departments, all of which are actively engaged in the new development, which is the provision of a day hospital for elderly patients with some degree of mental confusion. Most of these patients have been drafted to the day hospital after a spell in the acute wards. Dr. Cosin is convinced that such a day hospital can only work with full efficiency when it is part of an already well established unit.

The number of patients attending the day hospital is from eight to ten daily, totalling some 50 to 60 attendances each week. They are accommodated in the occupational therapy department and go to the main hospital for their midday meal, being collected from their own homes in transport arranged by the hospital shortly after breakfast and returned there in the early evening. The day is spent in varying forms of occupational therapy, basket-making being most popular. Those in need of physiotherapy treatment attend by appointment in that department, which is conveniently near. The matron, Miss E. G. Selby, arranges for another important service—the bathing of patients whose home facilities are inadequate; this is done on the wards by the nursing staff.

Evidence of the success of this experiment is seen in the fact that whereas four or five years ago the waiting list at Cowley Road Hospital was at least as long as for the average hospital caring for the chronic sick, today it has no waiting list and admits some 1,000 patients annually.

Those patients for whom the day hospital is most suited are elderly people with some degree of mental confusion, who present a most serious problem in their own homes. If left alone, they are not only unsafe to themselves and others, but are quite incapable of attending to their own needs. If living with friends or relatives, they eventually become an overwhelming strain for anyone responsible for their sole care, and yet if admitted to a geriatric unit they occupy a bed for an indefinite period which could otherwise be used for a succession of acutely sick elderly folk for whom at present no provision can be found.

An even worse situation arises when their mental confusion is so unnecessarily aggravated by their living conditions that the only solution that offers is a bed in a mental hospital, and because of that the admission of younger patients for whom early treatment would mean recovery is delayed.

An interesting example of the type of patient attending the day hospital at Cowley Road Hospital was a blind woman, 86 years of age, who had been admitted to an acute ward with a fractured thigh, incontinence and intermittent mental confusion. She lived in the basement of a house with her daughter, who in addition to the care of her own invalid husband, let the upper part of the house as lodgings to undergraduates. When, after a spell in hospital, the fracture refused to unite, the daughter was at first reluctant to take her mother home, but was persuaded to do so on the understanding that she would be re-admitted at once if the situation became too difficult. It was also arranged that she should spend at least four days each week at the day hospital. The result was gratifying; not only was a reasonable degree of lucidity regained and incontinence overcome, but the old lady showed such skill and aptitude for basket work that she was awarded a prize in an open craft competition.

The men include several who have suffered one or more strokes and who find that the concentration called for by weaving or basket work is often as beneficial as the physiotherapy which helps to restore their movement,

Those engaged in any form of care for the aged sick will admire this new and valuable contribution made in Oxford. They will also rightly wonder if a similar type of care might not be provided for the many others suffering from physical illness and disability. Might it not be part of the answer for those to whom the Minister of Health referred when he said: "the mesh in the Welfare State is too wide, and in this field the line blurs between those in need of hospital treatment and in need of care."

Measured in terms of new interest and life to the patient and untold relief to those responsible for his home care, its effect could be invaluable. Much could be done, too, by a suitably qualified person, either attached to the unit, or perhaps making regular visits to dispersed units, and arranging informal meetings with groups of the relatives of these patients, at which problems could be discussed and instruction given to help in the nursing of them at home.

The elderly love their homes, and while a day hospital may not provide a complete answer, any scheme that enables them to keep contact with their familiar surroundings deserves careful study. May not such a scheme also prove to be one further indication of the changing pattern of nursing care?

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The Conjoined Twins of Kano

by IAN AIRD, Ch.M., F.R.C.S., Professor of Surgery, University of London; Director of Surgical Studies, Postgraduate Medical School of London, Hammersmith Hospital.

THE term 'conjoined (Siamese) twins' is usually applied to twins who are united bodily but possessed of separate personalities. It has therefore been used to include a great variety of twins monstrously joined, and has included partners who have shared various combinations of trunk and limbs. Those of surgical interest include the so-called 'symmetrical conjoined twins', though this term is perhaps unfortunate in that conjoined twins are seldom completely symmetrical; they differ from each other usually to some degree in appearance, and their internal organs may partly or wholly each be a mirror image rather than a replica of their partner's.

Formation of Conjoined Twins

It is usually assumed that conjoined twins are monovular and due to fission of an embryo. If fission occurs at the stage of the inner cell mass before the embryonic disk has separated, separate twins result. If the twinning occurs after separation of the embryonic disk, there is only one amniotic sac. If the centres of axial growth are at this stage far enough apart there are separate twins in a single amniotic sac. If the centres of growth were not sufficiently separate the intermediate area between the two centres of axial growth might be shared and conjoined twins result (Potter, 1952).

It has never been completely proved that conjoined twins are in fact monovular. It is conceivable that separate twins might become joined from fusion of the closing edges of the neural grooves, for example, or from fusion of some other epithelial surfaces with their underlying mesodermal masses; but this would require disappearance of intervening amnion, a rare accident, as well as fusion of the twins. It is certainly curious that conjoined twins always differ from each other slightly in size and appearance, and are seldom so precisely identical as separate monovular twins are. Seventy-three per cent. of conjoined twins exhibit mirror imaging, while separate one-egg twins show this abnormality in only 22 per cent., the mirror imaging taking the form of a degree of *situs inversus viscerum*, which has never been explained satisfactorily. I have a record, obtained directly from a traveller, of Chinese conjoined twins, one of whom was a eunuch. There is also a report of twins joined at the pelvis, one of whom suffered from hypertension (Jones *et al.*, 1948). In one reported pair there was a hare-lip deformity in the case of one only, and, as in the Townsend twins of Alberta (Allin, 1953), the heart is often normal in one twin but the seat of Fallot's tetralogy or some other congenital cardiac defect in the other. In this connection it should, however, be remembered that in parabiosis of any kind one partner always becomes dominant.

Types of Twins

Conjoined twins may take the form of an *omphalopagus* (joined at the navel); a *xiphipagus* (joined at the lower sternum); a *thoracopagus* (joined in the chest); a *craniopagus* (joined by the heads); or a *pygopagus* (joined at the pelvis). The bridge of fusion may include an important internal organ. An omphalopagus may have a fusion of the two small intestines, or of the stomach, or of the liver. A craniopagus may have the two brains joined by a bridge of nervous tissue. When union is at the pelvis, urogenital organs may be shared, or if union is at the sacrum the spinal cords may be single at the level of the union. Rarely, one twin is included in the body cavity of the other as an 'included foetus' (Farris and Bishop, 1950).

The frequency of occurrence of conjoined twins is difficult to ascertain. Potter reports one specimen of symmetrical joined twins in the Chicago Lying-in Hospital in 60,000 deliveries; during the same period there was no example of such union in embryos or foetuses. The frequency of reports of conjoined twins is increasing, but it would seem that this is due to the increasing accessibility of very large populations in Asia and Africa, to the greater possibility of the successful birth of conjoined twins in improved modern obstetrical circumstances, and to the lessening likelihood now of conjoined twins being sacrificed as monsters at birth. My belief is that we may expect each year, over the world as a whole, the birth of half a dozen or more conjoined twins capable of separation. A number of survivors from the operation of separation of Siamese twins have come to my notice in the past few months, and not all of these have been reported in the medical press.

Only a minority of conjoined twins seem to cause dystocia, though at least one case of obstructed labour from this cause is reported (Roxburgh, 1946).

Some Historical Examples

A number of conjoined twins have become historically famous. The earliest case on record seems to be that of the Biddendon Maids born in A.D. 1100 in England, united from hips to shoulders and with only one pair of upper and one pair of lower extremities shared between them. The Florentine Twins, born in the 14th century and the subject of a bas-relief in the Church of La Scala and of a sonnet of Petrarch's, seem to have had three lower extremities between them and three upper, though successive mediaeval authors vary in their descriptions and illustrations (Belloni, 1950). The Scottish Brothers, joined from the waist down but separate above it, lived for 28 years at the Court of James III of Scotland in the latter part of the 15th century. The opposite abnormality—one head and chest and a double abdomen and pelvis, with four inferior extremities—has also been described (Rohrbach, 1950). In the 16th century female conjoined twins with three legs, the central one equipped with ten toes, lived at Middleton in England (Rueff, 1554), and during the same century there was a similar monster, carrying, however, only five toes on each of the three lower extremities, alive at Viaban in France. The Hungarian Sisters were born at Szorny in 1701 and survived in a convent for 22 years. The famous Siamese Twins, Chang and Eng (1811-74), have been fully documented elsewhere (Luckhardt, 1941). Born of Chinese parents in Siam in 1811 as a xiphipagus, they were discovered at the age of 13 by a British merchant. Removed to North America, they were shown in his circus by Barnum, married English sisters, and settled down as farmers in North Carolina under the name of Bunker. As in the case of most other conjoined twins, when one died the other refused separation. Hindu twins were on exhibition at the Paris Exposition of 1931. The Godino twins, born in the Philippines, applied for United States' citizenship. They were perplexed when the official response to their application was a warning that military service would be required of them; their sacral

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THE NIGERIAN SIAMESE TWINS

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Fig. 1. *Photograph of conjoined twins showing hernia of common umbilicus.*

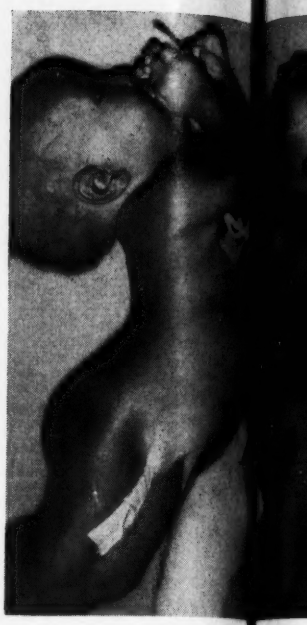


Fig. 2. *Investigating finger ... hernia ... peritoneal*

junction would have rendered it impossible for them both to have obeyed marching orders simultaneously (*N. Y. St. J. Med.*, 1937).

Previous Operations

Scammon (1925) recorded and described the operations performed for the separation of conjoined twins, including that performed by Doyen in 1902 for the separation of the Radica-Doodica sisters, one of whom had developed active tuberculosis: the tuberculous sister died, but the healthy survived. The earliest attempt at a surgical separation is said to have been made by Dr. Farius, of Basle, in 1689, but I have not traced the record of this operation.

In October 1912, conjoined twins were successfully separated at the Military Families Hospital, Portsmouth, by a R.A.M.C. officer whose name cannot now be traced. One of the sisters of this pair is alive to-day, age 41, and the scar of her operation can be seen on the lateral aspect of the hip. The other sister died of pneumonia at the age of four months, but there are no records to show whether or not she in fact had congenital heart disease. This would appear to be the first successful separation of conjoined twins.

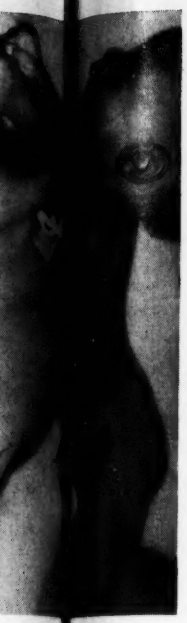
Dr. Holm of Minnesota successfully separated conjoined twins joined by the xiphoid cartilage on January 8, 1927, and they were alive and well nine years later (Holm, 1936). Dr. D. W. McLaren (1936) also successfully separated conjoined twins of a Hausa woman in the Sokoto Emirate of Nigeria on June 16, 1935, and the separated twins are alive and well today (McLaren, 1953). Here again the junction was of skin, subcutaneous tissue, and cartilage at the level of the xiphoid process. Three further separations were recorded last year in America in the medical and lay press. In one of these (Carolyn Anne and Catherine Anne Mouton) the junction was pelvic and both girls survived, one with an artifical anus. The second example, in Cleveland, Ohio, was a separation of twins joined by cartilage at the xiphisternum, both again surviving (Reitman *et al.*, 1953), and the third (Grossman *et al.*, 1953) was a craniopagus, with a common sagittal sinus which necessitated the sacrifice of one child, the other surviving. In 1953 a craniopagus was born in Bonn, Germany, but operation was, I understand, refused. A xiphipagus born at Molenend in Friesland was separated on June 12, 1954, in Leeuworden, Friesland by Dr. Straat. A thoracopagus at born in Greenock, Scotland, on March 20, 1954, survived for rather more than a day, and conjoined twins born in Hamburg, Germany, on the same day, are still alive at the time of writing.

Fig. 5. *Barium meal showing small intestine.*

Fig. 6. *Barium meal ... and rectu...*

Hazards of Operation

Surgical success is most likely to be obtained when the



ing finger hernia into peritoneal

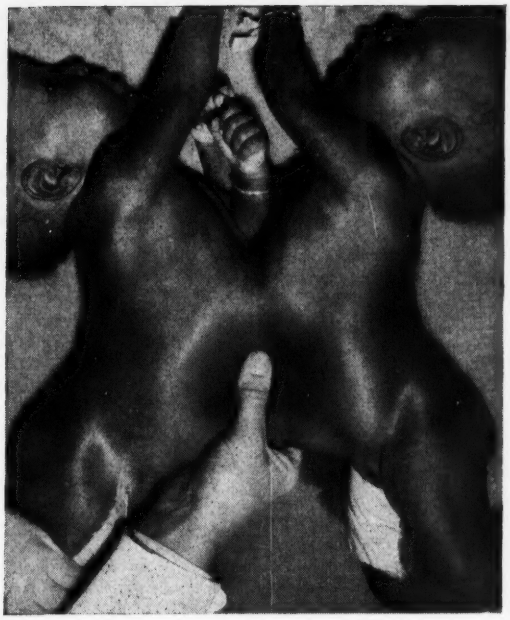


Fig. 3. *Lower part of 'bridge' joining twins.*

Fig. 4. *Barium meal filling stomach.*

a meal and rectum.

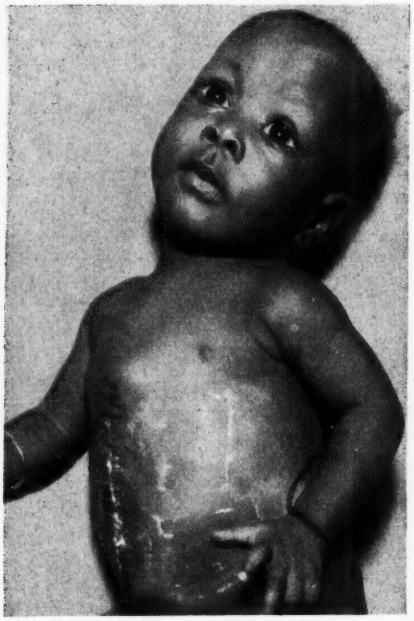


Fig. 7. *Photograph of surviving twin.*

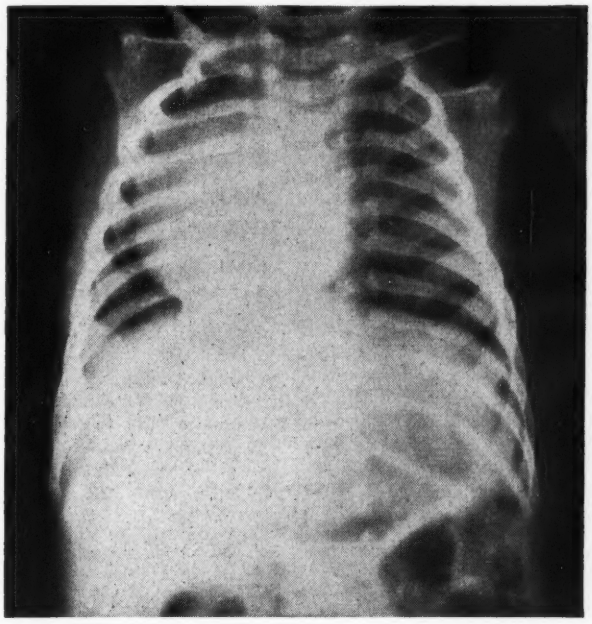


Fig. 8. *X-ray film of surviving twin showing dextro-rotation of the heart.*

union between conjoined twins is only of skin, subcutaneous tissue, and perhaps cartilage. I have recently been informed of several cases in which an umbilical junction of minor extent has been successfully separated just after birth and the event not thought worthy of medical record. The chance of success should also be high in twins joined at the xiphisternum by skin and cartilage only. Where a vital organ is shared—the liver or the brain—the division of that organ may render operation hazardous. In any event, and however great the risk of the death of one or both children, it would seem that operation should nearly always be undertaken if the children are known each to have a full complement of the organs and tissues necessary for separate life.

The diagnosis of conjunction, usually made during labour, has only twice been made before labour has begun (Graber, 1945; Becker, 1950).

On March 22, 1954, a thoracopagus was born at Hastings, Sussex. The mother's previous obstetric history was of a miscarriage at 12 weeks' gestation in 1947 and a full-time pregnancy in 1949. There was a history that the paternal grandmother had had three sets of normal twins. There was a pre-natal diagnosis of twins, both presenting by the head. Labour began at term on March 22. One head presented at the vulva next morning, but further progress was arrested and traction was in vain. The presenting baby died during these efforts to deliver it. The obstetrician

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(Mr. John F. Foulkes) was summoned, and his examination revealed the presence of conjoined twins. In view of their size, delivery by the abdominal route was undertaken and accomplished, both babies being now dead. The mother has made a good recovery.

These twins were joined from the sternum at the level of the third costal cartilage to the umbilicus. The lower part of the communicating bridge took the form of a substantial exomphalos through the wall of which four umbilical veins, one pair on each aspect of the bridge, could be seen passing from a single placenta, diverging from each other on each aspect of the bridge and coursing together again, appearing to join at the edge of the exomphalos. Dissection of the specimen showed that each infant had an oesophagus and stomach, but that the two pyloric canals entered a single duodenum which was continued as a single small intestine to a point about half-way along the small intestine, where there was a pouch resembling a Meckel's diverticulum, though placed at a much higher level than usual; and from this pouch two separate enteric channels continued, one to each infant. The large intestines were normal. The liver was joined and no gall-bladders could be found. There appeared to be two sets of bile passages and each infant had a pancreas. A single heart, anatomically abnormal in a complex way, served both infants, and only one of the infants was possessed of an aorta. In the other infant no vessel or vessels suitable to take the place of the aorta could be found. These infants, though externally not substantially dissimilar to the conjoined twins of Kano, could not have been separated with any hope of the survival of both, and it seems unlikely that even one of them would have survived operative intervention. The complexity of their union shows the need for the most extensive possible investigation before the surgical separation of conjoined twins is attempted.

The Kano Twins

The conjoined twins which are the subject of the present paper were born in Kano, Nigeria, to a mother of Ibo race, on July 25, 1953. They were rotated at birth with respect to each other; one presented as a vertex, the other as a breech. A diagnosis of plural birth had not been made. The twins were successfully and safely delivered by a pupil midwife. Their weight at birth was 7 lb. 13 oz. (3.5 kg.). They were nursed at the breast, the mother learning to support them both in a suitable position for feeding together.

X-ray examination after the feeding of barium to one twin showed already while they were in Nigeria that the alimentary tracts were separate.

The twins were admitted to Hammersmith Hospital on Friday, November 13, 1953. Both were then in good health, and their joint weight was 18 lb. 1 oz. (8.7 kg.). One twin, Wariboko, was noticeably larger and more active than the other, Tomunotonye, and the facial appearance of each was quite distinct. They were not in the literal sense identical even though presumably uniovular.

The twins were joined by a bridge which extended from the sixth costal cartilage to the navel. The bridge was 14 cm. in its long vertical diameter and 37 cm. in circumference. There were a single common navel and an umbilical hernia which depended from the lowest part of the bridge (Fig. 1). This hernia could be invaginated, the invaginating finger passing easily into both peritoneal cavities (Fig. 2), which showed that the peritoneal cavities communicated at least in the lower part of the bridge. There was a firm ring of muscle around the neck of the hernia, which admitted two fingers, and it thus seemed certain that the bridge had a substantial muscle wall in its greater part. In its lower part the bridge could be compressed between finger and thumb (Fig. 3) so that its two walls met. In its uppermost part it contained a hard tissue which was deduced to be cartilage; it seemed to arch over the upper part of the bridge formed by the fusion of the sixth, seventh, and eighth costal cartilages, and the lower part of the sternum. Even below palpable cartilage the bridge could not be fully compressed in its upper half.

A heart beat could be heard over the chest of each child, but it was impossible on auscultation to decide whether the beat was separate. The children breathed in unison and consequently sucked synchronously when fed. This was a matter at first of some apprehension, in case the diaphragms should be extensively intermingled and the pericardial cavities perhaps in communication with each other. It was then recalled, however, that animals artificially joined in parabiosis breathe synchronously, apparently as a matter of convenience, and it was hoped that synchronous breathing was a matter of convenience in these twins rather than a sign of seriously extensive anatomical union of their respiratory organs.

It is perhaps of psychological interest that each infant sucked her own and her sister's thumb almost indiscriminately and with equal and mutual satisfaction.

Investigations

A series of special investigations was undertaken to decide whether operative separation afforded any prospect of success.

X-ray Examination

A straight X-ray film failed to demonstrate visibly the cartilage bridge between sternums and ribs. (This feature can be seen in Figs. 4, 5, and 6). Both spines were lordotic from the infants constantly straining away from each other, and the sternums both sloped forward towards each other from the upper to the lower ends. The heart shadows were clearly separate from each other. In repeated X-ray examinations the intestines filled the lower part of the bridge, but in none of the very numerous plates were hollow viscera seen to occupy the upper third of the bridge. In the very uppermost parts of the bridge a clear gap was observed between the two livers and the outlines of the opposing faces of the two livers were thought to be distinguishable; yet there remained a rather hazy shadow between these two outlines, and a bridge of liver tissue crossing from one infant to the other could not be excluded.

An opaque-meal examination was undertaken in Nigeria, barium being fed to one infant. This showed clearly that stomach (Fig. 4), small intestine (Fig. 5), and colon and rectum (Fig. 6) were separate for each child. It showed in addition that the pylorus of one child lay at least 3 in. (7.6 cm.) from the pylorus of the other, and therefore it was assumed that the two duodenums were substantially separate from each other, and consequently that at least the lower ends of the common ducts were separate too.

Cholecystography was next performed. The gall-bladders were both visible, well separate from each other. Consequently it was deduced that the common ducts must be separate at their upper ends and, since their lower ends were also considered above to be separate, presumably throughout their whole length. It was assumed that if the bile ducts were separate the portal veins would be separate also.

Intravenous pyelogram was performed at the same time as blood and circulation studies were done in order to preserve at least one great saphenous vein in each baby to be used for transfusion at the time of operation. An intravenous catheter was in each infant passed by way of the saphenous vein into the common iliac vein. A pyelogram showed that each infant had two kidneys placed well back in the paravertebral region. From this is was deducted that the renal arteries, and probably therefore the aortas, were in their normal situations. Anomalies of the great vessels are frequent in conjoined twins and a common ventral aorta was to be feared. The pyelogram seemed to exclude this particular danger. The bladders were well outlined, separate from each other, and there was no visible junctional canal between them, as might be found by the union of one allantois with the other.

Electrocardiography

Electrocardiographic studies were undertaken by Dr. T. Counihan. They proved to be of special cardiological interest, sufficient to require separate description, and Dr. Counihan's description of the electrocardiographic changes and discussion of their implications will be described in a separate paper. The individual electrocardiographs of both children were essentially normal. In a joint electrocardiograph the Wariboko complex was inverted, and this infant was

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shown later to have a dextro-rotation of the heart This joint tracing showed clearly that the heart rates were different.

Investigation with Radio-isotopes

Mr. N. Veall, formerly of the Radiotherapy Unit, and Dr. P. L. Mollison, of the Transfusion Research Unit of the Medical Research Council, both situated in Hammersmith Hospital, undertook a study of the circulatory connection between the two infants. A known dose of radioactive red cells was injected by intravenous catheter into twin 1. Gradually the injected cells, circulating across the bridge, mixed with the circulating blood of twin 2. The concentration of radioactive blood in twin 1 consequently gradually fell, and the concentration of radioactive blood in twin 2, as measured in successive specimens by Geiger-Muller counter, gradually rose, until equilibrium was reached with complete mixing. From the rate at which the proportion of radioactive cells in twin 2 increased, the rate of blood flow across the bridge could be deduced. Mr. Veall prepared a graph which showed the rise in radioactivity in the blood of infant 2 and the fall in that of infant 1. The curve was, as expected, an exponential one, but it showed that there was a slight time-lag in the early part of the curve. This would be compatible with the blood in the injected infant having to complete nearly the whole circle of the circulation, passing through not only pulmonary and systemic capillary beds but also the hepatic sinusoid bed before crossing the bridge. The presumption that liver lay in the bridge was extremely strong.

Decision to Operate

The investigations seemed to show that both infants were fully equipped with all the organs necessary for separate life. It was not possible to predict whether the separate organs would necessarily function adequately after separation, but it was unfortunately not anticipated at this point that one of the pair might be contributing more, and one less, than the other to the total endocrine production. The only hazard of operation would seem to be the liver union which was confidently predicted; but this was not felt to be an insoluble barrier, though division of a common liver might well add to the shock of the operation. There was no previous record of the successful separation of twins so extensively conjoined. The investigations seemed to have shown that the portal veins and common bile ducts were separate. It was decided to operate without further loss of time to avoid increasing the spinal lordosis and the forward angling of the sternums.

The Operation

The mother was prepared for operation in case a vein or fascia graft or temporary skin cover by homograft should be required.

Instruments

Only two special instruments were included in our armamentarium, a liver tourniquet of fine soft rubber (Penrose) tubing, as used by Dr. Allin of Edmonton, who lent his film of a previous separation, and Schumacher intestinal clamps for application to the liver bridge if it was narrow enough.

Anaesthesia

Since the vascular communication across the bridge gave complete mixing of the twins' blood only after 29 minutes it was obvious that both must be separately anaesthetized, and two anaesthetic teams were arranged. Nitrous oxide and oxygen anaesthesia was chosen, and each infant was to be separately intubated and to be anaesthetized by means of a separate anaesthetic apparatus.

For an operation of such magnitude on babies so young blood transfusion was obviously essential, and Dr. P. L. Mollison, Director of the Medical Research Council Transfusion Research Unit, catheterized the remaining saphenous veins so that transfusion would be entirely dependable.

The twins were placed on an operating table with the headpieces and footpieces dropped, and the double anaesthetic was induced without difficulty. A remarkable phenomenon was observed during the induction of anaesthesia. As has already been stated, the respiration of the twins before operation was synchronous. As the induction of anaesthesia proceeded, and while the children were breathing still voluntarily, each through its own anaesthetic apparatus, the character of the breathing changed, and a kind of see-saw respiration developed, one baby inspiring as the other exhaled. Gradually the tempo of respiration again changed, until each settled down at its own pace. The explanation of these respiratory changes must be exceedingly complex. Once induction was complete intubation proceeded and was effected without difficulty.

Towelling the Twins

The special arrangements for towelling were learnt also from the Canadian film. A team of nurses supported the twins horizontally over the operating table and well clear of it, while the skin of the whole trunk of each, and of the bridge between them, was cleaned. A series of four towels were then applied to the babies, one towel wrapping the head and upper chest of each, and the others the lower extremities. The towelled babies were then placed on the operation table. Two surgical teams were in readiness, each consisting of surgeon, assistant, and instrument nurses, the two surgeons to separate the twins and then each to conduct one closure. Other specialists were additionally available to advise in the solution of unexpected problems in particular fields, and an anatomist to help unravel internal anatomical abnormalities, especially the complicated and varied venous plexuses sometimes present in such twins on the under surface of the liver.

Initial Phases

It was decided first to explore the bridge directly through its presenting obverse surface, the incision being made initially from the cartilage bridge to the navel. The alternative would have been to start at the lower limit of the bridge, dividing the parietes on both obverse and reverse aspects, and closing the two abdomens from below upwards *pari passu* with the division. This might have been less shocking, but would have been clumsy and slow, and control of escaping viscera might have been awkward. The anterior approach to the abdominal cavity and to the liver, leaving the parietes on the far side undivided until the end of the operation, would, it was thought, permit the intestines to be easily packed off throughout the whole period of operation. The number of hands in the operation field was restricted to four, which ought to be sufficient for control of the abdominal contents and for retraction. A multiplicity of hands is a hindrance in the neighbourhood of so small a wound.

The skin having been divided, a reasonably thick sheet of abdominal muscle presented, equal to the whole thickness of the normal infantile abdominal wall, though not separated in layers. When this was divided, peritoneum appeared in the lower part of the wound and the liver bridge could be detected in the upper part. A cushion pad of suitable size inserted under the bridge was now found to enhance the exposure substantially.

Since it was known that there was a common peritoneal cavity, extending at least across the lower part of the bridge, where the hernia could be invaginated, the peritoneal cavity was first opened here. It was now clear that the peritoneal cavities communicated only at the lowest extremity of the bridge in the neighbourhood of the hernia. The peritoneal incision had in fact entered the peritoneal cavity of baby 1. It was extended now up as far as the liver, and it was clear that the peritoneal cavities communicated freely below, but above were separated by a slender dividing veil which stretched across the whole thickness of the bridge. The peritoneal cavity of baby 2 was now opened in the same way.

The intestines were now packed off carefully, the packs being inserted along the surface of the peritoneal partition to reach the abdominal wall on the far side of the bridge. The nature of the peritoneal partition was now clear. Above, it was attached to the liver, and inferiorly it had a crescentic edge concave downwards. Its attachment to the near and far walls of the bridge extended down to the navel, and to its surfaces were attached the falciform ligaments. The upper

part of this partition, just below its attachment to the liver, was now divided, together with the falciform ligaments. There was the expected plexus of veins in relation to the under surface of the liver and the falciform ligaments, but this gave less trouble than was expected. Care was nevertheless taken to clamp carefully the peritoneal folds of the liver before their division.

The Liver

It was now clear that the central part of the common liver could not be satisfactorily exposed for division until the bridge of cartilage which crossed from one chest wall to the other had been at least partly divided. It proved to take the form literally of a bridge or arch, being concave downwards in the coronal plane and forming a cartilage roof over the upper part of the common liver. It cut easily with the knife, but was really so rigid that it was surprising to recollect that the babies had been twisted through 90 degrees at birth. After the bridge had been divided to a point beyond its summit, the remaining cartilage on the far side yielded sufficiently for a much better view of the liver to be obtained. Care was taken not to distract the two infants from each other. It was felt that stretching of the liver after the loss of its cartilage protection might exert dangerous traction on the hepatic veins and on the diaphragm. The division of the cartilage did, however, give a much wider view of the presenting surface and of the inferior surface of the common liver, and the two gall-bladders could be demonstrated in the situations where cholecystography had shown them to lie. Obviously the next stage of the operation must be division of the liver through its centre in the bridge. No obstruction was met to a finger passed round the bridge to reach the lower edge of the liver on the far side.

At this stage of the operation it soon became clear to us how valuable was the method of liver control devised in Edmonton at the operation on the Townsend twins. In passing the forceps which would later guide the tourniquets round the liver bridge it was clearly desirable to keep as far as possible, on each side, from the centre of the liver. If the tourniquets lay too close together on the far side of the bridge they might easily slip through the cleft in the divided liver when liver division was completed. Consequently each artery forceps was induced to find its own separate way round the far side of the liver as far as possible from the median plane of the bridge. Each Penrose rubber drainage tube followed easily the path of its guiding forceps, and the tension made by this tubing when finally controlled by clip was very comfortable. It was estimated that the tourniquets lay 5 or 6 cm. from each other on the far side of the liver, and that there would not be much danger of their slipping when liver division was completed. It was found more convenient to divide the liver by knife and scissors than to tear through it with forceps, though the consistency of the liver varied from place to place: in one place it would be easy to tear through soft liver substances, while in another it was necessary to use sharp dissection.

When liver division had proceeded through approximately three-quarters of the bridge a thin band of liver tissue remained on the far side, and it proved easy to apply a Schumacher clamp and to divide the remaining liver between the clamps: though a variety of clamps were in readiness, this particular type was, as had been expected, the most suitable for the purpose. By rotation of the clamps towards the operator the raw surface of the liver of baby 1 could now be inspected. It was easy to distinguish open blood vessels and bile ducts, and these sustained the application of artery forceps surprisingly strongly without tearing. Indeed the impression was obtained that the divided vessels on the cut surface of the liver of this baby were easier to control than are those of the adult liver.

It had been intended to trim the cut surface of the liver to a concave shape so that its edges could be sutured together by stitches through Glisson's capsule, and the liver surface was inspected while consideration was given to this step. It was felt highly desirable to close the raw surface in this way lest bleeding should occur with the increase in liver flow which follows operation, and to avoid the oozing of bile into the peritoneal cavity, so commonly followed in babies by subphrenic abscess. In fact the question did not arise, for the liver tissue proved to be so flexible and elastic that the cut edge of Glisson's capsule on the far side of the raw surface could be brought quite readily forwards for suture. After division of the liver the abdominal contents had to be packed off again on each side to afford a view of the undivided peritoneum on the far side of the bridge. Division of the remaining cartilage link was now completed, and the soft tissues on the far side of the bridge were divided from within outwards.

Closing the Abdominal Wall

In closure of the abdominal wall a single layer of stitches was employed for muscle and peritoneum. In the upper part of the closed abdominal wound the heart could be seen beating through the opening in the diaphragm, where diaphragmatic muscle had presumably been united across the bridge under cover of the cartilage roof. That part of the cartilage body which now appertained to each child protruded in an unsightly way and had to be trimmed, but care was taken in trimming not to leave too much of the pericardial sac exposed. The procedure was now identical for the two children at the two separate tables except in so far as the liver of baby 2 had still to be sewn over after the moment of separation. The last stage in closure was to trim the skin over the hernia that had been present in the lower part of the bridge, and to excise on each side what remained of the hernial sac. The quality of the muscle in both babies was rather poor at this level, and the muscle closure at the lower end of the wound, though complete, gave rise to some doubt of its strength.

As separation approached completion the second team came into play. This proved to be really quite a complicated manoeuvre. Its abdominal contents kept in place by packs and manual pressure, the baby, complete with transfusion apparatus, had to be carried to the second table, the anaesthetist moving over with his apparatus too. The manoeuvre was completed without mishap.

It might be said at this point that all pre-operative predictions were, as has been seen, fulfilled as the operation proceeded, and the plan of the operation proved reasonably sound. There was, however, one fault in the planning which should be considered when this operation is repeated—the difficulty of an accurate swab count at the end of the operation which starts as a single operation and finishes as two operations performed by two separate teams. This did not occur either to the surgical or to the nursing planners until the time came to count the swabs at the end of the operation, when for a few minutes it proved extremely difficult to establish that no swab was missing.

The abdomen of the second baby was now closed, and the total operating time from the first incision to the insertion of the last stitch in the second baby was one hour and 35 minutes.

Thus at the end of the operation two apparently normal and separate babies were obtained. Their general condition was good, and the circulation of each was entirely satisfactory. The babies were in as good shape as any babies of that age are after an abdominal operation. The babies were returned from theatre to ward in a double oxygenaire specially constructed by the Oxygenaire Company to contain both. On their return to the premature baby unit, still in good shape, they were transferred to separate oxygenaires.

Collapse of Tomo

One hour after their return, while still under close inspection, Tomo suddenly collapsed. The chest was opened and the heart massaged for an hour. A ventricular rhythm returned but no normal beat. Post-mortem examination showed no cause for death. There had been no bleeding and the liver closure was perfect. There was no cardiac or other abnormality. The lungs were airless and oedematous, as is usually observed *post mortem* after artificial respiration with oxygen through tracheal tube and cardiac massage. The only possible cause of death lay in the adrenal gland. This was only about one-third of its normal weight as measured by the adrenal/renal weight ratio. It is possible that the surviving twin had been responsible in life for the greater part of the production of cortisone for the pair, and that the

dead twin had insufficient adrenal-cortical tissue to withstand the shock of the operation. When this operation is done again it would be wise to give both twins cortisone, for usually in such a partnership one twin is dominant, providing more for, and taking more from, the joint organism. It is notable that after Holm's successful separation of twins conjoined only by skin, muscle, and cartilage one infant was noticed to be particularly pale and collapsed.

The Surviving Twin

The surviving baby's wound was well healed on the 10th day of her post-operative course (Fig. 7), and it gave rise to no anxiety whatever. There remained a weakness of the lower end of the wound, and this baby has the umbilical hernia which is exceedingly common among Nigerian babies. There is a protuberance also where the cartilage bridge was divided, and this is to some extent due to the rather acutely sloping sternum, the children when joined having striven always to pull away from each other, a fact which led to distraction of the xiphisternum on each side forward in front of the upper part of that bone. X-ray examination of the surviving baby (Fig. 8) shows now dextro-rotation of the heart. But the electrocardiogram was not that of a *situs inversus*; there was therefore no true mirror-imaging of the twins present. The surviving baby and her mother left hospital to return to Nigeria on December 21, 18 days after operation.

ACKNOWLEDGEMENTS

I must express my gratitude to Dr. A. O. Sasegbon, of Kano Hospital, for offering us this rare surgical problem, and for the excellent clinical notes which he furnished of the birth and early life of the twins in Nigeria. I must also pay public tribute to Dr. Eardley S. Allin, of Edmonton, for sending us his film of the operation on the Townsend twins; we learnt much from it.

I am indebted to many colleagues for assistance with the management of these twins. Professor Alan Moncrieff supervised the paediatric problem they presented in his Premature Baby Unit at Hammersmith Hospital. Dr. R. Steiner was responsible for the radiographic detail. The anaesthetic arrangements were supervised by Dr. H. Woodfield-Davies, with the assistance of Dr. A. Ryan. Dr. T. Counihan undertook the electrocardiographic studies. For the precise prediction of the size of the liver bridge we are indebted to the radio-isotope work of Mr. N. Veall, formerly of the Medical Research Council Radiotherapeutic Unit at Hammersmith Hospital. All the intravenous work before and during the operation was undertaken by Dr. P. L. Mollison, of the Medical Research Council Blood Transfusion Research Unit at Hammersmith Hospital; Dr. Mollison's previous experience of infant transfusion made his services invaluable on this occasion. Mr. Selwyn Taylor co-operated with me in the operation on the babies and was responsible for the closure of one of them. Professor W. J. Hamilton, Professor of Anatomy at the Charing Cross Hospital Medical School, advised us on the vascular anatomy to be expected in the bridge, assuming a common liver. I am grateful to Dr. I. Doniach for his report on the post-mortem findings in the case of the twin who died.

The return journey Kano-London-Kano of baby and mother, together with nurse, was defrayed by the United Africa Company. The cost of their treatment as private patients in Hammersmith Hospital was borne by an anonymous donor.

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Florence Nightingale

Sir Edward Cook's biography is published in serial form to commemorate the centenary of Florence Nightingale's departure with her nurses for the Crimea; this is the 27th instalment.

Miss Nightingale was consulted by many authorities on the planning and design of new hospitals, but her main work during the end of the year 1856 and the early part of the next was preparation for the Royal Commission. She had been asked by Lord Panmure to write a report on her Crimean experiences, and she produced within six months a formidable report entitled 'Notes affecting the Health, Efficiency, and Hospital Administration of the British Army'. It was never published, but much of it, and many of her recommendations at the end, were embodied in the Report of the Royal Commission in due course.

STATISTICIANS, sanitary engineers, architects and other experts were all in communication with Miss Nightingale during the preparation of her Report. Dr. William Farr, the first authority on statistics, was at work with her early in 1857 upon comparisons of the mortality in the army and in civil life. "It will always give me the greatest pleasure", he wrote, "to render you any assistance I can in promoting the health of the Army. We shall ask your assistance in return in the attempts that are now being made to improve the health of the civil population . . ." When Miss Nightingale had finished the statistical section of her Report, she sent the proofs with her illustrative diagrams to Dr. Farr. He found nothing to alter, and he specially commended her diagrams for the clearness with which they explained themselves. She was something of a pioneer in the graphic method of statistical presentation. In every branch of her inquiry she was equally thorough; consulting Sir Robert Rawlinson and Sir Edwin Chadwick, and Sir John Jebb, the architect of model prisons. She collected plans of all the best hospitals in Great Britain and on the Continent. She consulted Professor Christison on dietetics, and procured dietaries from foreign hospitals. She corresponded with Army surgeons, Army chaplains and missionaries.

Miss Nightingale's Report was more than half finished when the long-promised and long-delayed Royal Commission on the same subject was appointed. Lord Panmure called at the Burlington Hotel with the Official Draft of the Instructions for the Commission. Miss Nightingale suggested a few alterations, and these were accepted, and the documents were sent for the Royal approval. Miss Nightingale kept a copy and sent it to her friend, Dr. Graham Balfour, the secretary of the Commission. "Every one of the members of the Commission", she explained to him, "was carried by force of will against Dr. Andrew Smith, and poor Pan has been the shuttlecock."

It throws an interesting side-light on the relations of Ministers to their subordinates to know, from Miss Nightingale's papers, that Lord Panmure was careful to have the documents initialled by the Queen before submitting them to Dr. Smith. To those who have delved into the history of the Crimean muddle, few things are more curious than the long ascendancy of Dr. Smith. Perhaps no one was to blame, but only the system; but if any individuals were to blame for the medical defects, then surely the Medical Director-General must have been one. Lord Grey admired the skill with which Miss Nightingale had marshalled the facts in her Report, but maintained that the true conclusion to be drawn from them was not that radical reform was needed, but that several persons (including Dr. Smith) should have been court-martialled. I doubt if Miss Nightingale differed from the latter proposition. But in fact Dr. Smith was decorated, and when the war was over he was allowed for many months to obstruct the course of reform. Dr. Smith, who was a pertinacious man, had, I dare say, many criticisms to make on the Instructions for the Commission. But, if so, Lord Panmure had a conclusive answer. What the Queen had initialled must not be altered.

The Royal Warrant, instructing the Commission, was on very wide and comprehensive terms, and the Commission

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set to work without a day's delay. Six months had elapsed between Mr. Herbert's acceptance of the Chairmanship and the issue of the Royal Warrant. The Report of the Commission was prepared in exactly three months. A mountainous mass of detail was accumulated and sifted, and no praise can be too high for the unremitting attention, the incessant hard work which Mr. Herbert, as Chairman, threw into the task.

But even so, such speed in the preparation of the Commission's Report would have been impossible, but that much of the ground had already been explored, and most of it exhaustively covered, by Miss Nightingale. There was an " Inner Cabinet " of three—and one of the three was not a member of the Commission—Mr. Herbert, Dr. Sutherland, and Miss Nightingale. There was no man so closely associated with Miss Nightingale's work for so many years as Dr. John Sutherland. He was recognized as one of the leading sanitarians of the day. As head of the Sanitary Commission sent to the Crimea in 1855, he had made Miss Nightingale's acquaintance, and from that time forth they were close colleagues. He served on almost every Commission, Sub-Commission and Committee with which she had anything to do. If he was not nominated she always insisted on his inclusion. He sometimes exasperated her, but they worked together in constant comradeship.

'. . . A MASCULINE INTELLECT'

Throughout the proceedings of the Commission, Miss Nightingale was in daily communication with Mr. Herbert or Dr. Sutherland, or with both. Mr. Herbert consulted her about the order in which to call the witnesses. He asked her to look into a comparison of the mortality among marines and sailors respectively. She secured on another subject some damning documents. " I return your stolen goods ", he wrote. " Pray keep them carefully. If ever we have to besiege the Army Medical Department, no Lancaster gun could be more formidable than this document; it is really almost unbelievable." Again: " I should very much like to have a Cabinet Council with you to-day. Shall I come to you at 5 o'c, or would you come here ? " And so forth, almost daily.

As each branch of the inquiry came up, she sent him a memorandum upon it. She suggested the witnesses and often saw them before they gave their evidence. In the case of some important witnesses, she prepared the briefs for cross-examination, as well as examination.

A difficulty arose as to whether Miss Nightingale should or should not give evidence herself. She was averse from doing so, and Sir John McNeill strongly supported her, in view of the strain and her great physical weakness at the time. In the present day she would of course have been made a member of the Royal Commission. In those days the idea of calling a woman as a witness caused some qualms. It was finally decided that Miss Nightingale should give evidence in the form of written answers to written questions. Her evidence, which occupies 33 pages of the Blue-book, is in effect a summary of her confidential Report. " It may surprise many persons ", wrote an army doctor at the time, " to find from Miss Nightingale's evidence that, added to feminine graces, she possesses, not only the gift of acute perception . . . but that she reasons with a strong, acute, most logical, and, if we may say so, masculine intellect, that may well shame some of the other witnesses." " I have perused with the greatest interest ", wrote a member of the Commission (Sir. J. R. Martin) to her, " your most conclusive evidence . . . It contains an assemblage of facts . . . which must prove of the most vital importance to the British soldier for ages to come."

The Report of the Commission was written by Mr. Herbert in August 1857, with much assistance from Miss Nightingale, but was not issued to the public until January 1858. It was shown conclusively by the Royal Commission that, as Miss Nightingale had said, the rate of mortality at home in time of peace was double that of the civil population. A comparison of the civil and military mortality in certain London parishes was yet more startling. In St. Pancras the civil rate was 2.2; the rate in the barracks of the 2nd Life Guards was 10.4. In Kensington the civil rate was 3.3; the rate in the Knightsbridge barracks was 17.5. Every one who knew the contents of the Report perceived that this was the point which would cause a sensation. The Crimean War was beginning to fade into the past, and reorganization of a department of the Army would be unlikely to arrest popular attention.

But the case was different with facts and figures showing that the health of the Army, even when at home and in peace, was shamefully sacrificed by official neglect. There was to be a sitting of Parliament in December, and nasty questions would assuredly be asked unless something were done. There was a masterful and importunate woman behind the scenes who was firmly resolved that something should be done. Without a moment's rest, without thought of recess or relaxation, Miss Nightingale flung herself into a new campaign.

Every generation of reformers sees some object on which its heart has been set deeply interred under a pile of Blue-books. This was the danger with which Mr. Herbert and Miss Nightingale were confronted in August 1857 in the case of their Royal Commission on the sanitary condition of the British Army. Against the risk of an equivocal Report they had, indeed, guarded themselves in advance; but the danger of a definite Report leading to no immediate action had still to be met. Mr. Herbert was no less anxious than Miss Nightingale. He had devoted unsparing toil to the Commission, which would be reduced to futility if their Report were merely to be pigeon-holed. They laid their plans on the effect which the disclosures of the Royal Commission were likely to have on public opinion.

Mr. Herbert communicated the gist of the Report privately to Lord Panmure, pointing out that it was " likely to arrest a good deal of general attention "; that there was time to take measures of reform before the Report became known to the public; that the simultaneous publication both of its recommendations and of measures founded upon them would " give the prestige which promptitude always carries with it." He put the case with his usual suavity. But there was iron within the velvet. The publication of the Report could be postponed for a while, but not indefinitely. Lord Panmure had to choose between committing himself to instant reform, so as to whitewash the Government beforehand, and postponing reform, in which case he would have to reckon with a public opinion inflamed by the disclosures of the Report. And meanwhile Miss Nightingale still held *her* Report in reserve, to publish should the negotiations fail to secure any guarantee for prompt reform.

"THE WIPING COMMISSION"

The plan of active reform agreed upon between her and Mr. Herbert was that four Sub-Commissions should be appointed, with Mr. Herbert himself as Chairman of each: (1) To put the Barracks in sanitary order; (2) to organize a Statistical Department; (3) To institute a Medical School; and (4) To reconstruct the Army Medical Department, to revise the Hospital Regulations, and to draw up a Warrant for the Promotion of Medical Officers. This last, from its comprehensive and cleansing scope, was called by Miss Nightingale " The Wiping Commission ".

Mr. Herbert seemed to carry his point with Lord Panmure, the four Sub-Commissions were agreed to in general terms. But Miss Nightingale heard that Dr. Andrew Smith was putting up a stiff fight against reform. Lord Panmure was in the Highlands shooting grouse, and paying only flying visits to London. His subordinates were as laborious as ever in piling up objections. He became frightened at his own acts, and revoked (but afterwards, under pressure, re-instated) the authority he had given for the Wiping Sub-Commission.

Miss Nightingale drafted instructions and schemes for each of the Sub-Commissions. There were meetings in her rooms to settle the procedure. There were periods, as Miss Nightingale afterwards recalled, " when Sidney Herbert would meet the Cabal, as he used to call it, which consists of ' you and me and Alexander and Sutherland, and sometimes Martin and Farr ', every day, either at Burlington

Street, or at Belgrave Square, and sometimes as often as twice or even three times a day."

Sir John McNeill considered that, compared with the work that Miss Nightingale was doing now, what she had done at Scutari was "mere child's play". All her friends, and Dr. Sutherland as a medical man more especially, saw that she was overworking. Change of air and seclusion she found at Malvern, but rest from work she would not. Whether at the Burlington or at Malvern, she desired to use every hour of strength for her work and for nothing else.

Dr. Sutherland urged her to take at any rate a week's complete rest. But she would not. Her cause was her life. While they were delaying, the soldiers were dying.

So little was Miss Nightingale in a mood to succumb to her physical weakness, that she offered to go out to India, where her friend Lady Canning was at the Viceroy's side during the Mutiny. "Miss Nightingale has written to me," wrote Lady Canning to her mother (Nov. 14); "she is out of health and at Malvern, but says she would come at 24 hours' notice if I think there is anything for her to do in her 'line of business'. Had the Viceroy felt the need of accepting Miss Nightingale's offer, it is possible that her power of will and the excitement of activity might have carried her through; but she had barely strength for the work on which she was already engaged. At the end of 1857 she thought that death might overtake her in the middle of her work with Sidney Herbert, and she wrote to him a last letter "to be sent when I am dead", and summing up "the work that remains to be done".

But by May 1858, her work for the health of the British soldier at home was beginning to bear fruit. A debate had taken place in the House of Commons (May 11) when Lord Ebrington, prompted by Mr. Herbert and Miss Nightingale, had moved a series of resolutions with regard to the health of the Army, founded upon the Report of the Royal Commission. He called attention to the horrible state of the Barracks, and his Resolutions concluded: "That in the opinion of this House, improvements are imperatively called for not less by good policy and true economy, than by justice and humanity." The Government accepted the Resolutions, and Miss Nightingale's campaign had thus obtained the unanimous approval of the House of Commons.

(to be continued)

Ministry of Health

Minimum Age for Nurse Training

HM (54) 44 deals with the scope of the General Nursing Council's power to waive the requirements of Rule 10 (2) of the Nurses Rules, 1951 (S.I. 1951/No. 1372), which prescribes the age of 18 years as the minimum age of entry to nurse training.

1. Rule 10 (2) of the Nurses Rules, 1951, came into operation on August 1, 1952, and since that date a number of hospital authorities have made application to the General Nursing Council for the waiver of the requirements of the rule in certain circumstances. While the Council have found it possible to waive the rule in some instances, they have, after consultation with the Ministry, found it necessary to refuse the applications in the majority of cases. Many of the applications which have been received and continue to be received appear to be based on a misunderstanding of the extent of the Council's powers in this matter and it has accordingly been thought that hospital authorities would welcome some guidance on the point.

2. It is clear from the wording of the rule that the power of waiver exists only where in the Council's opinion its strict application "would be likely to affect the hospital services prejudicially". This can only mean that in considering an application for waiver the Council must have regard to the staffing situation in the hospital in question and are empowered to waive the rule only where its strict application would result in such a reduction in the number of student nurses as would seriously affect the nursing services of the hospital. The rule gives the Council no power to waive these requirements in favour of individual candidates for training by reference to their educational or other qualifications.

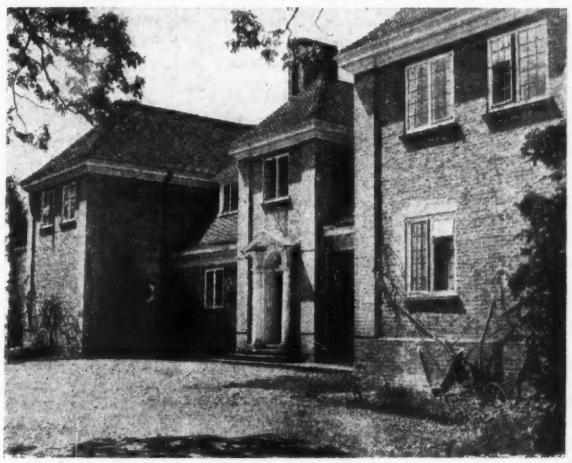
[MAY 27, 1954]

BRACKEN HILL HOUSE

A Pioneer Hostel for Rheumatic Sufferers

MISS Pat Hornsby-Smith, Parliamentary Secretary to the Ministry of Health, opened the pioneer hostel for rheumatic sufferers at Bracken Hill House, Northwood, Middlesex, on Tuesday, May 25. Sir Walter Puckey, chairman of the B.R.A. Homes Ltd., in his opening speech referred to the great numbers of people who suffered from rheumatism in some form or another, estimating that it crippled some 2,000 people yearly and as a result it was one of the greatest handicaps in industry today. Of these 2,000 people, 60 per cent. could be cured, he said, if treatment was given in the early stages.

Miss Hornsby-Smith emphasized the great number of women in the home afflicted in addition to those employed in factories, etc., and she went on to say that she felt that this field of experiment was pre-eminently suited for voluntary efforts; "I can only say that the Ministry welcomes such experiments and will watch keenly and be ready to learn from the results." A vote of thanks was given by the Rt. Hon. Tom Williams, P.C., M.P., LL.D., chairman of the British Rheumatic Association, who also gave a first-hand account of the suffering caused by the disease.



The British Rheumatic Association's new hostel at Northwood, Middlesex.

The aim of the hostel is to "prevent permanent crippling through delay in obtaining up-to-date diagnosis and treatment."

Patients at Bracken Hill House will receive treatment at Mount Vernon Hospital, which is two miles from the hostel—transport being supplied by the hospital car service. The B.R.A. is a voluntary organization but treatment received will be under the National Health Service at the hospital. The rooms of the hostel are well furnished and gay with coloured chintz. The bedrooms differ in size from three to five bed dormitories at £4 15s. to single rooms from £6 6s. to £7 7s.; these charges are inclusive, and can be met by the employing firm's personnel welfare fund, from a benevolent or similar fund, by the patient or from grants from the patient's insurance company.

The British Rheumatic Association is inviting firms to endow beds, and so provide accommodation for their employees suffering from rheumatism. A two-year financial guarantee of £1,000 has been given by Lord Nuffield against any loss in operation. The hostel has 25 beds at the moment and hopes to increase to 52; it is staffed by a qualified matron, the rest of the staff being domestic.

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Student Nurses' Association

IMPORTANT DATES

JULY

Reminder. Quarterly business meeting of Unit should be held either in July, August or September.

SEPTEMBER

Area Reports. Northern Ireland and Scotland Reports should reach the Editor of the *Nursing Times* by September 15.

Area Speechmaking Contests will be held as follows.

NORTHERN IRELAND, SEPTEMBER 4—full details to be published later.

NORTHERN AREA (NORTH WEST), SEPTEMBER 28, at Manchester Royal Infirmary.

NORTHERN AREA (NORTH EAST) SEPTEMBER 30, in the Conference Room, Leeds Regional Hospital Board, Harrogate.

EASTERN AREA at the Royal Victoria Hospital, Folkestone, during the first two weeks—full details to be published later.

LONDON AREA during the first two weeks—full details to be published later.

AREA SPEECHMAKING CONTESTS

CONDITIONS

1. Competitors must have been members of the Student Nurses' Association on or before May 31, 1954. Only one entrant will be allowed from any Unit, *and only the first 12 valid entries received can be accepted.*
2. Each entrant must make a speech of not more than five minutes' duration on the given subject.
3. Speeches may not be read, though very brief notes will be allowed.
4. Marks will be awarded not only for the speech itself, but for the way in which it is delivered.
5. Applications must be made on an 'A' form and countersigned by the matron of the training school.
6. Applications must reach . . . . by first post not later than . . . .
7. The decision of the judges will be final.
8. Failure to comply with any of the above conditions will disqualify.

MIDLAND AREA in Birmingham—full details to be published later.

SCOTLAND in Aberdeen—full details to be published later.

WESTERN AREA—full details to be published later.

NOTE

Members are reminded that the Area Contests are being held in preparation for the Final Contest for the Cates Trophy, which will take place in London on Friday, November 26.

Annual Report

Additional copies of the Annual Report are available on application to the Secretary—use it during the year for your Unit programme planning.

Unit Report

North Devon Infirmary, Barnstaple

The North Devon Infirmary Unit of the Student Nurses' Association has had a very active year, beginning in March, when a donation of £5 was given to the Mayor's Appeal for the Canvey Island Relief Fund. On May 20, Miss N. Richards and Miss N. Stowell attended the Annual General Meeting of the Association, and Miss Richards gave a full report of it on her return.

Two events took place in June: a fancy dress coronation ball, held in Queen's Hall, and a jumble sale at Trinity Church Rooms. The profit from the jumble sale was £16 11s. 9d.

During August a garden fete was held, but owing to bad weather it had to be taken into the physiotherapy department and the boardroom; this did not seem to affect the profit made, as £35 0s. 4½d. was raised by the fete.

On September 17 the student nurses held a farewell party for Miss M. Wright, matron, and presented her with a cheque, for which they had collected.

On January 7 this year, the students gave a Christmas party and invited the matron, sisters and all the other nursing staff.

E. B. KEENAN.

Q.A.R.A.N.C. ASSOCIATION

AN unusual feature of the Q.A.R.A.N.C. Association reunion was that it was, for the first time, immediately preceded by the members' annual general meeting held in the same hotel. This was arranged for the convenience of the members, many of whom come great distances to attend the reunion, and being unable to undertake the journey twice are sometimes thus deprived of the opportunity of joining in the discussions on Association affairs.

Eighty-two members were present at the meeting which was an important one as a new chairman was to be appointed and an outstanding development of the Association discussed—that is, the formation of possibly a dozen or more new branches based on some of the larger military units.

In 1948 Dame Louisa Wilkinson, D.B.E., R.R.C., on her retirement, undertook to establish the Association and has served in the dual capacity of chairman and administrator since then. She did not accept renomination as chairman this year and Lt. Col. P. Widger, recently retired from the Q.A.R.A.N.C., was unanimously appointed chairman—the chief office in the Association.

Aims and Objects

The aims and objects of the Q.A.R.A.N.C. Association can be summed up in the one word 'friendship'—between those who serve or have served in the Army Nursing Services. It is an all-ranks Association and embraces South African War veterans and the newly-joined recruit together with the 'in-betweens', past and present, of whatever variety—Regulars, Reserves, Territorials and several others.

Miss Daisy Bridges, C.B.E., R.R.C., is the vice-chairman and another Territorial, Mrs. E. H. Mills (*née* Taylor) is the able Friends' Secretary, responsible for the Benevolent Section which has a visiting scheme among its other activities through which older or sick members are personally contacted. Miss E. A. Baldock, A.R.R.C. (Q.A. Res.), matron of St. Thomas' Babies Hostel, is the hard-worked treasurer and Mrs. B. Cobden (*née* Ewbank) (Q.A.Res.) is assistant to Col. N. P. de B. Bampton, editor of the Association quarterly gazette. Mrs. D. M. Hammond (*née* Abel) is chairman and readers' representative on the gazette committee. Miss M. A. V. Hind, retired Q.A.I.M.N.S., is membership secretary. All are voluntary workers and really enjoy it.

A general secretary is urgently needed to supervise, co-ordinate and deal with committee matters at head office. It would entail two or three visits to 20, John Islip Street, S.W.1, a week and any member thinking of offering is assured of an interesting sideline.

With the new branches scattered over a wide area, it is hoped to enrol many more members and to expand benevolent and social activities on even more personal lines than has hitherto been possible.

Membership subscription is 7s. 6d. per annum which includes the quarterly gazette. Life members can be enrolled at £5 5s. on agreement to subscribe to the Gazette at 5s. per annum.

Potential members on application to Q.A.R.A.N.C. Association, 20, John Islip Street can be put in touch with the branch nearest their homes or can be placed on the headquarters register if no branch is convenient. The Association is trying to double its membership this year.

Nursing Times Tennis Tournament

Second Round Results

HARPERBURY HOSPITAL beat WEST MIDDLESEX HOSPITAL. A, 6-4, 6-4, 4-6; B, 6-1, 2-6, 6-2. Teams. Harperbury: A, Mrs. Walker and Miss Wickham; B, Misses Pender and Elliott. West Middlesex: A, Misses Seaney and Sen; B, Misses Dirdle and Mrs. McKay.

WHIPPS CROSS HOSPITAL beat the HOSPITAL OF ST. JOHN AND ST. ELIZABETH. A, 6-1, 6-2, 6-3; B, 7-5, 6-2. Teams. Whipps Cross: A, Misses Coston and Brown; B, Misses Vousden and Hickey. St. John and St. Elizabeth: A, Misses Turne and Smith; B, Misses Waldron and Lamb.

GUY'S HOSPITAL beat EDGWARE GENERAL HOSPITAL. A, 6-3, 4-6, 6-4; B, 3-6, 6-2, 6-2. Teams. Guy's: A, Misses Collier and Oates; B, Misses Putt and Brown. Edgware General: A, Misses Jobling and Cole; B, Misses M. and B. Fairbrother.

UNIVERSITY COLLEGE HOSPITAL beat BEXLEY HOSPITAL. A, 3-6, 2-6, 1-6. B, 6-3, 6-1, 6-1. Teams. University College: A, Misses Luther and McArthur; B, Misses McBride and Byrom. Bexley: A, Misses Brace and Creeth; B, Misses Wallace and D'Orsaneo.

NURSING THROUGH UNDERSTANDING

by W. KEITH NEWSTEAD, S.R.N., R.M.N., R.F.N., Principal Tutor, Bracebridge Heath Hospital, Lincoln.

THE time is now here when we must discuss the progress made, and being made, by the nursing profession in this country, and compare it objectively with the progress of medicine.

We are living in an era in which the term ' psychosomatic medicine ' is receiving great prominence, but this term is like a new cover for a very old book. Many centuries have passed since Socrates said: " Just as you ought not to attempt to cure the eyes without the head or the head without the body, so you should not treat the body without the soul; where this is not in a good state, it is impossible for a part to be well." Even at the turn of this century the gestalt school of psychology advanced among its basic laws: (1) nothing exists but as a part of and in dynamic relation with the whole; (2) parts derive their properties from the whole; the whole takes precedence over its parts in time and space; (3) the whole conditions the activities of its parts and possesses insight, will, and function through its parts; (4) parts emerge from the whole through a process of individuation.

The modern term ' psychosomatic medicine ' is a good one, as it must constantly remind us of the ever-present connections between the functions of the mind (psyche) and body (soma). It is being increasingly brought home to us that whether the sick person is suffering from an apparently obvious disease of the mind, or an equally obvious disease of the body, we must take into consideration *all* the biological facts—anatomical, physiological, pathological and psychological. In other words, if we are to understand the individual as a human being we must study him as a complete whole.

As a profession sharing the responsibility for preventing ill-health and treating disease, we must of necessity ask ourselves whether we *are* in fact as progressive in our nursing reforms as are our colleagues in the field of medicine.

Recently we have put into operation the revised General Nursing Council syllabuses, and I think it must be unanimously agreed that not only has much serious thought been put into their compilation, but that they are most definitely a step in the right direction; but have they stepped far enough ? I venture to say most definitely *not*.

In view of recent findings that the previously held notion that psychological illness was one thing and physical illness another is absurd, and that it is now a proved fact that abnormal personality reactions may provoke abnormal functions of body organs, and disturbed organic function may cause mental disorders, I fail to see why, instead of issuing a more comprehensive syllabus to all types of hospitals, the General Nursing Council did not give us the basic training we realize is so vitally necessary if we are to play our full part in ' *nursing through understanding* '.

We must in all sincerity ask ourselves if it is right that we should continue to turn out ' general trained nurses ' when, looking at it objectively, the training is anything but general.

It can be argued that the new syllabus for general nurses has been brought up-to-date by the inclusion of mental disorders, psychotherapy, social aspects of disease and other related branches; but I wonder what practical insight a student can gain from *two* lectures on mental disorders (including psychosomatic disorders), which are the number allotted in their curriculum ?

It may be thought that the recent experimental schemes of integrated training between general and mental hospitals, mental and mental deficiency hospitals, general and sick children's hospitals etc., are a move in the right direction; but I maintain that this only emphasizes the lack of courage on the part of the nursing authorities.

Surely the time has arrived when we should all be ' general trained ', with the necessary practical experience to ' nurse through understanding ' any sick person, anywhere.

It is our responsibility as members of the *health team*, to make sure that every human being is given a chance to attain the fundamental right of positive health; but before we can possibly make our contribution to the full, we must be certain that all members of the profession are trained to have a complete understanding of both the normal and abnormal patterns of human behaviour.

At the first session of the Expert Committee on Nursing, WHO, held in Geneva in February 1950, the Committee in their recommendations called attention to the need for the review of basic education programmes to ensure that they prepare nurses for the continuous evolution of modern health work. At the Working Conference on Nursing Education held in Geneva in March-April 1952 (Miss M. Houghton, education officer, General Nursing Council for England and Wales, was present), it was agreed that ". . . the kind of nurse who is needed in all parts of the world is one who is prepared, through general and professional education within the social structure of the community in which she/he lives, to share as a member of the health team in the care of the sick, the prevention of disease, and the promotion of health."

Members of the Working Conference went on to say that this kind of nurse would be one who " is prepared to recognize and to adjust to changing social, economic, medical, nursing and health conditions . . . is equipped, through generalized preparation, to work in *all* fields of nursing . . . is prepared to give *total* nursing care, including the physical, mental, emotional and social elements."

Those of us interested in the ' total health welfare ' of the human being, are going through a trying period of frustration, which perhaps may not be obvious to colleagues who have limited practical experience in only one branch of nursing. If one wishes to give the ' total nursing care ' advocated so forcibly by the WHO Working Conference, it has been, and still is, necessary to chase certificates in order to gain the requisite practical experience to teach and nurse through understanding, surely this fact alone shows only too clearly the devastating weaknesses in our current method of nurse education.

I would appeal to all nurses interested in meeting the total health needs of the community to study the WHO reports on nursing, and to insist through their professional organizations that we in this country provide a nursing education which will produce nurses who are able to give our peoples the broad conception of health which is most assuredly the basis of peace and security throughout the world.

Dedication of Hospital Chapel, Stratford

THE presentation and dedication of a chapel for Queen Mary's Hospital for the East End, London, was held on May 13, by the Rt. Rev. Henry A. Wilson (Bishop of Chelmsford, 1929-1950) in the presence of H.R.H. the Duke of Gloucester. Dr. L. Comyns, J.P., chairman of the West Ham Group Hospital Management Committee, presided, and told how in the past 93 years the hospital had never had a place of worship and how very grateful they all were to have one now.

He then called on Mr. Cleminson, chairman of the Hospital Aid Committee, who reported that after reconstruction of the hospital, which was severely damaged in the war, was completed, the Aid Committee had decided to celebrate the jubilee with a gift of a chapel. It had taken 50 years to raise the sum of £50,000, of which £10,000 had been spent on the chapel. Special thanks were due to Mr. S. C. Aspden, secretary of the Hospital Aid Committee, for the work he had done.

Lord Lyle of Westbourne, J.P., patron of the Aid Committee, then presented the Queen Mary's Chapel to the chairman of the hospital management committee. The presentation took the form of a parchment in an oak casket.

The platform party then proceeded to the Chapel with the guests to take part in the service. The Duke of Gloucester, who was received by Colonel Sir Francis Whitmore, K.C.B., C.M.G., D.S.O., Lieutenant for Essex, met members of the reception committee, including Miss M. H. Davies, matron. The service was relayed

to the outpatients hall and to wards, with a running commentary by Raymond Baxter of the BBC, so that all could join in. *The Lord's my Shepherd* was sung with a descant by 14 nurses of the hospital choir. The Duke of Gloucester visited the chapel and the outpatients hall. On the Duke's departure members of the nursing staff formed a guard of honour at the entrance.

ROYAL SANITARY INSTITUTE

At the examination for health visitors, approved by the Minister of Health, held in Liverpool on May 27, 28 and 29, 17 out of 22 candidates were successful.

XUM

Royal College of Nursing

Education Department

METHODS OF TEACHING PARENTCRAFT

Special Part-Time Course

In an effort to meet the needs of many experienced health visitors who are teaching parentcraft and health to various groups, the Education Department proposes to arrange a further part-time course on one day a week (Friday).

This will be a departure from the usual plan of arranging lectures on two evenings a week, as it has been thought it would assist those who are prevented by distance from travelling to London for evening lectures and might be administratively easier for health authorities, in that all teaching practice classes etc. would take place on the Friday of each week, leaving the student with no further commitments with regard to the course during the rest of the week.

Fees for the course, which is approved by the Ministry of Health, will remain unchanged at £15 15s. with a reduction of £5 5s. for members of the College.

The course will cover two terms as follows:
First term: October 1—December 17.
Second term: December 31—March 11.

Sister Tutor Section

Sister Tutor Section within the North Western Metropolitan Branch.—There will be an extraordinary general meeting at the West London Hospital, Hammersmith, W.6, on **July 13**, to discuss the future conduct of the Preliminary State Examination. Miss Bocock has kindly agreed to open the discussion at 7 p.m.

Occupational Health Section

Newcastle Group.—There will be a meeting of the Group in Room 561 (fifth floor), Carliol House, Newcastle-upon-Tyne, by kind permission of The British Electricity Authority, on **Monday, July 5,** at 7 p.m.

North West London Group.—A meeting will be held at the Royal Masonic Hospital, Ravenscourt Park, W.4, on **Wednesday, July 21,** at 6.15 p.m.; it will be followed by a Branch meeting at 7 p.m.

Branch Notices

Blackpool and District Branch.—A general meeting will be held at Moss Side Hospital, on **Monday, July 12,** at 7 p.m., to receive the report of the Annual General Meeting.

Buckinghamshire Branch.—A business meeting will be held at Holly Cottage, Speen, Nr. Aylesbury, by kind invitation of Mrs. B. I. Greenmon, on **Thursday, July 8,** at 7 p.m.

Ipswich Branch.—A meeting will be held at 30, Fonnereau Road, Ipswich, on **Monday, July 19,** at 7.15 p.m. Mrs. Blair-Fish will talk on *The Professional Setting and the Representation desirable for a Complete Nurse*. A cordial invitation is extended to all trained and student nurses.

Leicester Branch.—The next meeting will be held at the Leicester Royal Infirmary on **Tuesday, July 6,** at 6 p.m.; O. Englander, Esq., M.D., D.M.R., will give a talk on *Radiotherapy*.

Membership forms for the College may be obtained from the General Secretary, Royal College of Nursing, Henrietta Place, Cavendish Square, W.1, or local Branch secretaries.

Glasgow General Meeting

A general meeting was held in the Scottish Nurses' Club, Bath Street, on Tuesday, June 22. Resolutions for the Branches Standing Committee were discussed, and Miss M. S. Miller gave a report of the Brussels visit which had been enjoyed by all.

Miss Peachie agreed to act as chairman during Miss Morrison's coming visit to Nigeria.

Harrogate Public Health Section

A meeting of the Public Health Section within the Harrogate Branch was held at the Maternity and Child Welfare Centre, Harrogate, on Tuesday, June 22. Following a short business meeting, an address was given by Miss Tarratt on various matters of interest, including the legal question of the nurse, and the work and training of the health visitor. The meeting ended with a discussion on the question of co-operation with the general practitioner.

NURSES APPEAL

Nation's Fund for Nurses

I expect many of you have already been enjoying holidays and feel rested and stimulated by all you may have seen and done. I wonder if you would care to send a holiday thank-offering donation, however small, to help our sick and elderly nurses to enjoy a similar few days' holiday? In past years we have, through your generosity, been able to arrange for some of our older nurses to enjoy and benefit from a change either in the country or by the sea, and we hope very much to be able to do so again this year.

Contributions for week ending June 26

	£	s.	d.
Health Visitors, Jarnsley	3	10	0
Miss M. M. Blakeley	3	0	0
Hayes. *Monthly* donation		10	0
Anon.	2	0	0
Total	**£9**	**0**	**0**

W. SPICER,
Secretary, Nurses Appeal Committee, Royal College of Nursing, Henrietta Place, Cavendish Square, London, W.1.

Appointments

Victoria Hospital, Lewes, Sussex

MISS JEAN C. A. BARROWMAN, R.F.N., R.G.N., S.C.M., Housekeeping Cert., took up her appointment as matron on June 22. Miss Barrowman has just returned from Southern Rhodesia where she spent two years as assistant matron of the Greenwood Park Nursing Home, Salisbury. She trained at the Western Infirmary and at the Royal Maternity Hospital in Glasgow, also at Manchester Royal Infirmary and at Gateside Fever Hospital, Greenock. Miss Barrowman went as assistant matron to Bishops Stortford Hospital in 1939 and after four years took up the post of matron at the Leeds Public Dispensary. In 1945 she became matron of the Whitehaven Hospital and two years later was appointed to the Stockton and Thornaby Hospital as matron, where she remained until she went to Southern Rhodesia in 1952.

Simpson Memorial Maternity Pavilion, Edinburgh

MISS MARGARET C. DARTON, S.R.N., S.C.M., M.T.D., takes up her appointment as assistant matron on August 1. After taking both general and midwifery training at St. Thomas' Hospital, Miss Darton remained there as charge nurse in the maternity ward and was later district sister and mothercraft department sister. She then became a ward sister at Park Prewett Emergency Hospital, Basingstoke, and afterwards served as sister-in-charge at Morrisburne Emergency Maternity Hospital and as assistant matron at Ashwood Emergency Maternity Hospital, both in Woking. She is at present an administrative sister at St. Thomas' Hospital, having returned there from Woking to become superintendent midwife.

Warwick Hospital, Larkin Road, Warwick

MISS JOAN HOBBS, S.R.N., S.C.M., Diploma in Nursing, University of London, Sister Tutor Cert. (Battersea Polytechnic), takes up her appointment as matron on September 1. At the completion of her training at King's College Hospital, Miss Hobbs joined the staff and has remained there until the present. After serving for a year as staff midwife, she went, in 1939, to the Horton Emergency Hospital as ward sister, later becoming sister tutor and in 1947 assistant matron there. She also served for a year as assistant matron of the Dulwich Hospital Unit of King's College Hospital, returning to Denmark Hill in 1948 as night superintendent. Since 1949 Miss Hobbs has been principal sister tutor at King's College Hospital.

Colonial Nursing Service

The following appointments have been made by Queen Elizabeth's Colonial Nursing Service.

Promotions and transfers. As nursing sister—Miss F. H. Courtney, Uganda.

Other appointments. As nursing sister—Miss E. M. Findlay, Hong Kong.

Obituary

Dr. J. S. Johnstone

We regret to announce the death of Dr. John Stephen Johnstone, consultant psychiatrist and deputy medical superintendent at Menston Hospital, near Leeds, for the past seven years. He collapsed and died in his residence at the hospital on June 14. About an hour before his death he had captained the hospital cricket team in an evening match against Bradford Royal Infirmary.

Dr. Johnstone was a native of Aberdeen and qualified at Aberdeen University. Before going to Menston he had held posts at King Street Mental Hospital, Aberdeen, and Whittingham (Lancs.) Mental Hospital. During the last war he served in the Army as a psychiatrist and reached the rank of Lieut.-Colonel. He saw service in South East Asia.

He was one of the leading personalities at the hospital and took an interest in every aspect of hospital work, devoting his whole life to mental patients. He was keenly interested in all aspects of nurse training and mental nursing, and was an examiner for the General Nursing Council.

Miss R. S. Drever

A Memorial Service for Miss R. S. Drever, late assistant matron, West Middlesex Hospital, Isleworth, will be held in the hospital chapel on Monday, July 5, at 5 p.m.

The Position of Nurses EMPLOYED BY BRITISH ELECTRICITY AUTHORITY

IN February 1952 representatives of the nursing staff employed by the British Electricity Authority first came to the College to discuss the position with regard to negotiations concerning their salaries and conditions of service. The College had a number of meetings with representatives of the Authority to discuss this matter; subsequently the Authority informed the College that it was not possible to regard the College as an appropriate organization under Section 53 of the Electricity Act 1947.

As a result of representations by members, the attention of the Council of the College was drawn to the salary scales of State-registered nurses employed in the medical departments of power stations, which were not in accordance with those recommended by the College. On January 9, 1953, a letter was sent to the Rt. Hon. Lord Citrine, P.C., K.B.E., C.I.E.E., asking that these scales be reviewed and brought in line with the College recommendations. In reply Lord Citrine reiterated the Authority's interpretation of Section 53 of the Electricity Act 1947 and said that it was not possible for the College to be represented on the National Joint Council for the purpose of negotiating on behalf of nurses.

The College pointed out that when the Authority had come to their decision in regard to organizations which they deemed to be 'appropriate', no nurses had been employed by the Authority. Since that time there had been no consultation with the College or other organization normally regarded as representative of nursing.

In the circumstances the Council of the College had no alternative but to report the matter to the Ministry of Labour and National Service as a dispute. This was a cause for regret, especially as the College has established friendly relationships with other public authorities, with whom it negotiates on behalf of nursing staff; it was difficult to understand why the British Electricity Authority was unable to grant similar recognition.

As a result of the intervention of the Chief Industrial Commissioner, further meetings were held and on November 6, 1953, a salaries claim on behalf of all members of the nursing staff was presented to the British Electricity Authority (published in the *Nursing Times* of November 21, 1953). This claim was discussed with the Authority who undertook to get in touch with the College before any final agreement was reached. It was therefore with great surprise that, on inquiry, it was found, in February 1954, that the Authority had reached an agreement with the National Joint Council, without further reference to the College.

On examining the National Joint Council scales and grading set out below, it will be seen that the salaries, particularly those of the senior staff, are lower than those proposed by the College. The College does not approve of the inclusion of nurses in the grades of clerical and administrative workers, for it feels that it is most important for nurses with their special duties and responsibilities to have their own salary scales and appropriate conditions of service.

BRITISH ELECTRICITY AUTHORITY

	Grade	Salary Scale				
		£		£		£
Chief Nursing Officer	8	895	×	35	—	1,000
Nursing Superintendent	4	605	×	20	—	665
	5	670	×	20	—	730
	6	730	×	25	—	805
Group Nurses	2	485	×	20	—	545
	3	545	×	20	—	605
	4*	605	×	20	—	665

* where special duties and responsibilities warrant the higher grade.

Power Station Nurses	1	400	×	20	—	480
	2	485	×	20	—	545

State-enrolled Assistant Nurses

Grade 1, or the following scale:

*Men**	*Women†*
£300	£280
£315	£295
£330	£310
£350	£325
£370	£340
£390	£355
£410	£370
£430	£385
£450	£400

*(£300 × £15 — £330 × £20 — £450)

†(£280 × £15 — £400)

Note: The National Joint Council agreed that the scales for nursing superintendents should be applied as follows.

Grade 4: Where duties and responsibilities are limited to a Division only.

Grade 5: Where duties and responsibilities cover an average Division and Area Board.

Grade 6: Where duties and responsibilities cover a larger Division and Area Board.

COLLEGE PROPOSALS

	Salary Scale				
	£		£		£
Chief Nursing Officer	850	—	1,250		50 (8)
Nursing Superintendent	750	—	900		30 (5)
Group Sister	550	—	650		20 (5)
Sister in Charge					
5—9 nursing personnel ...	480	—	620		20 (7)
1—4 nursing personnel ...	460	—	600		20 (7)
Sister in Sole Charge	440	—	540		20 (5)
State-enrolled Assistant Nurse ...	325	—	425		12 10 (8)

* * * *

At a meeting on June 4, 1954, the College had an opportunity to put forward their point of view and to make representation regarding the following.

1. Salary Scales

(*a*) The scales are on the whole lower than those proposed by the College; an anomaly to which the College took great exception was the application of the same salary scale (£400-£480 per annum) to the State-registered nurse and the State-enrolled assistant nurse. It would appear that the Authority does not appreciate the difference in the qualifications and training of State-registered nurses and State-enrolled assistant nurses. The College requested the *Nursing Times* not to accept an advertisement from the Authority of a post vacant for either a State-registered nurse or a State-enrolled assistant nurse.

(*b*) *Unequal Pay.* The salary scale of the male State-enrolled assistant nurse is £20 at the minimum and £50 at the maximum above that of the female State-enrolled assistant nurse. The College strongly supports equal pay for men and women.

2. Allowance for Industrial Nursing Certificate

No allowance is made for possession of the Industrial Nursing Certificate which is an essential qualification for the nurse in industry. It will be known that the College recommendation is an additional £30 per annum to holders of this qualification.

3. Provision of Uniform

There is no mention of a uniform allowance or that uniform should be laundered free of charge. The College recommends that where uniform is not provided an allowance of £20 be given in lieu and that uniform be laundered and/or dry cleaned free of charge.

* * * *

The Council feels that members would wish to be kept informed of the progress of the discussions with this Authority and to give their support to the Royal College of Nursing in its endeavour to safeguard the professional status of the nurse in industry.

Student Nurses' Association

NURSING TIMES POSTER

The poster prepared by the *Nursing Times* in response to a request by the Student Nurses' Association is 10 inches by 12 inches in size, and coloured blue, white and black. It is available to all Student Nurses' Association Units from the Editor, *Nursing Times*, Macmillan and Co. Limited, St. Martin's Street, London, W.C.2.

HERE and THERE

WEST MIDDLESEX HOSPITAL

The Minister of Health, the Rt. Hon. Iain Macleod, recently re-opened Ward O.2, one of the geriatric wards at the West Middlesex Hospital, which he re-named ' King Edward Ward ' in recognition of the fact that it had been renovated and furnished with some of the most modern equipment in the country with the help of a grant from King Edward's Hospital Fund for London. With other speakers, the Minister paid tribute to the work of Dr. Marjory Warren, who recalled memories of the days when the hospital had been a workhouse, and she thanked the Fund's committee not only for the grant of money but for the co-operation and help they had given.

MENTAL NURSING CADET SCHEME

The Liverpool Regional Hospital Board has recently approved the establishment of centres for the training of nursing cadets at Deva and at Winwick Mental Hospitals, and has agreed that salaries shall be paid to cadets as follows: over 16 years of age—£150 a year; over 17 years—£160. Preferably, young people will not be recruited under 16 years of age, but in exceptional cases, and where the matron is satisfied as to the candidate's suitability, the salary will be 43s. per week.

Nursing cadets normally live at home, but should any become resident a charge of £90 per annum will be made. Local management committees are being advised that cadets' hours of duty should not be less than 38 or more than 44 each week, excluding meal times. The course is to be of general educational value, and general subjects will be taught in co-operation with the local education authority.

JOINT NURSING AND MIDWIVES COUNCIL, NORTHERN IRELAND

The number of successful candidates at the Final State Examinations held in May 1954 are as follows: General Part of the Register—78; Register for Male Nurses—3; Register for Mental Nurses—17; Register for Sick Children's Nurses—1; Register for Fever Nurses—11.

GLOUCESTERSHIRE ROYAL HOSPITAL

The annual reunion of nurses of the Gloucestershire Royal Hospital was held at the Southgate Street Branch on Thursday, June 3, and was attended by a large gathering of past and present trainees. A short service, conducted by the Rev. G. F. Hutchins, was held in the beautifully decorated hospital chapel; afterwards a very enjoyable tea was provided in the Nurses' Home. During tea a large birthday cake was cut by the matron, Miss E. Fensome, who had extended a warm welcome to all present.

MEDICAL FILM

The film *Relief of Pain in Childbirth* has been added to the I.C.I. Film Library, I.C.I. Ltd., Imperial Chemical House, Millbank, London, S.W.1. (Cat. No. M.33; running time 18 mins.; 16 mm.; colour. Made in collaboration with the Department of Gynaecology and Obstetrics, Guy's Hospital, London.)

After giving a definition of the ideal obstetric analgesic, a description is given of the two inhalation methods, nitrous oxide and trichlorethylene. The properties of nitrous oxide are described together with the principles of its administration; apparatus is shown.

Trilene is described together with the principles of its administration. Many inhalers are also shown, including the latest inhaler, which operates on the principle of a carburettor.

George Medal Award

Miss Freda Holland, night sister at Dellwood Maternity Home, Reading, has been awarded the George Medal for her heroic action. The citation states: " in rescuing the 15 babies when fire broke out in the nursery of the home last April, with complete disregard for her own safety, she fought her way through flames and smoke frequently re-entering the room though the floor was already burning and removed all the babies. In spite of burns of both arms and scorched face she continued to attend to the babies until ordered to hospital."

Miss Holland trained at the Manchester Royal Infirmary from 1939-1943 and took her midwifery training at the East End Maternity Hospital (evacuated to Hampshire), and Dellwood Maternity Home, Reading. She has held posts at maternity homes in Tunbridge Wells, Worthing and Reading before returning to Dellwood in 1952. Nurses and midwives will wish to accord their admiration of Miss Holland's gallant conduct and appreciation at this recognition.

Mrs. E. O. Jackson Memorial

The late Mrs. E. O. Jackson, formerly matron of University College Hospital, the Norfolk and Norwich Hospital, and Chairman of the Hospital Matrons' Association, was also Vice-chairman of the Northern Group Hospital Management Committee and the Committee have decided to commemorate her splendid service to the Group and to the nursing profession by inaugurating a memorial fund. The fund will be used to assist nurses of this group who are undertaking post-certificate study by the provision of a library and assistance with expenses connected with post-certificate courses which cannot be met from Exchequer funds.

The Committee feel that there are many members of the nursing profession who would like to be associated with this memorial to such an inspiring member of the profession. Donations should be sent to A. F. Gray, Esq., Group Secretary, Royal Northern Hospital, London, N.1, and made payable to the Northern Group Hospital Management Committee.

It has also been decided that a ward at Highlands Hospital, Winchmore Hill, N.21, which is now being reconstructed, shall be named after the late Mrs. Jackson.

DONCASTER ROYAL INFIRMARY

Mr. W. Moir Shepherd, M.D., F.R.C.S., who has served Doncaster Royal Infirmary as a consultant surgeon for 30 years' will be retiring towards the end of July and it is proposed to make a presentation to which past and present members of the nursing staff are invited to contribute. Contributions should be forwarded to the Matron.

STATE EXAMINATION QUESTIONS

General Nursing Council for England and Wales

Final General Examination

Medicine and Medical Nursing Treatment

Answer three questions only.

1. What are the common causes of chronic heart failure? Describe the signs and symptoms which may occur and state briefly the treatment which may be given to relieve the patient.

2. Describe an attack of bronchial asthma. State what you know about the causes and treatment of this condition.

3. Discuss the management of chronic constipation.

4. Describe a case of rheumatoid arthritis and give an account of the medical and nursing care of a patient during the acute stages of the disease.

5. State briefly what you know about: (*a*) laryngitis; (*b*) mumps; (*c*) quinsy; (*d*) thread worms; (*e*) urticaria.

Surgery and Gynaecology and Surgical and Gynaecological Nursing Treatment

Answer three questions only.

1. Discuss the signs, symptoms, complications and treatment of general peritonitis due to a perforated appendix.

2. Describe the treatment of a compound fracture of the tibia and fibula.

3. For what conditions may nephrectomy be performed? Discuss the post-operative treatment. What complications may occur?

4. What do you understand by haemorrhoids? Discuss the signs, symptoms and treatment of this condition.

5. Write brief notes on the following: (*a*) Bartholin cyst; (*b*) trichomonas vaginalis; (*c*) dysmenorrhoea; (*d*) erosion of cervix; (*e*) ring pessary.

General Nursing

Answer five questions only.

1. Describe the nursing care of a child of two years who is suffering from bronchopneumonia.

2. Describe the treatment and nursing care of a patient admitted to hospital acutely ill with food poisoning. Enumerate the causes of this condition.

3. Discuss the nursing care of a patient during the first four days after the operation of radical mastectomy. What complications may follow this operation?

4. A patient is admitted to hospital for the operation of gastrectomy. Apart from routine nursing, what special nursing care is required before and after operation?

5. What urinary disturbances may occur in patients suffering from gynaecological disorders? State in each case what the nurse may do to help the patient.

6. For what purposes are the following treatments prescribed: (*a*) magnesium sulphate enema; (*b*) starch and opium enema? Describe in detail the preparation and administration of one of these.

7. What constitutes a well-balanced diet? Give examples of (*a*) a full diet; (*b*) a light diet; (*c*) a fluid diet.

The Board of Examiners by whom these papers were set is constituted as follows: Miss M. M. C. Louden, M.B., B.S., F.R.C.S., W. G. Sears, Esq., M.D., M.R.C.P., Miss A. E. A. Squibbs, S.R.N., Miss F. Taylor, S.R.N.

..so naturally I prescribed Lestreflex

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OFF DUTY

At the Theatre

BOTH ENDS MEET, *by Arthur Macrae* (*Apollo*).

To judge from the applause there was no doubt which part of the theatre most enjoyed this comedy with its dominant theme of income tax evasion. Brenda Bruce as the imperturbable fiancée and Arthur Macrae as the young man torn between his conscience and the desire to straighten out his financial affairs, gaily piled up indiscretions with the able assistance of a solicitor friend (Cyril Raymond), and when Miles Malleson and Alan Webb appeared the tempo, and our enjoyment, increased. Few people meet income tax officials in the flesh but if Mr. Wilson (Richard Pearson) and Edward Kinnerton (Richard Easton) are typical, it would be an excellent idea to get together. Whatever one's views on the problems presented by income tax and legacies, laughter is inevitable in this chronicle of human frailty.

At the Cinema

The Seekers

The period of the story is 1820 when an Englishman first lands in New Zealand and is greeted in friendship by a Maori chief. He returns to England to fetch his bride, and together they set out to seek a new life in New Zealand where with a few followers they build a settlement. Life is hard and made harder by the plans of a fanatical priest who hates the white man. Starring Jack Hawkins, Glynis Johns, Noel Purcell and Inia Te Wiata.

Below the Sahara

This is a film hunting expedition in Africa —with camera, not guns. There are wonderful shots of every kind of game, all made by Armand Denis and his wife Michaela. A water ballet by pelicans is both charming and graceful. The whole film is packed with interest.

The Sleeping Tiger

This film has an interesting theme. A psychiatrist is held up by a young criminal with a gun; he overpowers him and makes a bargain—if the criminal will agree to living in his house for six months as a 'guinea pig' he will not be handed over to the police. The effect of this experiment on all concerned as the months go by is electric and works up to a dramatic climax. A well-acted film, starring Dirk Bogarde, Alexis Smith and Alexander Knox.

Executive Suite

A story of conflict in big business—the impact on five vice-presidents of the sudden death of their president who had not named a successor. None of those men can win the office without the vote of a woman who is the major stockholder. Well acted and extremely interesting with a cast packed with stars—William Holden, June Allyson, Barbara Stanwyck, Fredric March, Walter Pidgeon and Shelley Winters.

Trouble in the Glen

Orson Welles plays a man of wealth and might but little tact. He returns to the highlands of his grandfather and sets himself up as laird in the ancestral castle of the Menzies clan. He falls foul of the Glen Eachen folk by closing a right of way through his land. With all this is woven another story of an American returning to Scotland where he served during the war, and a child crippled by polio. Starring Margaret Lockwood, Orson Welles, Forrest Tucker, Victor McLaglen and John McCallum.

VistaVision

'The shape of films to come'—VistaVision is a most interesting new process introduced by Paramount. The film is fed *across* the lens from side to side instead of up and down, and the picture photographed on a negative more than two-and-a-half times the size of a normal movie negative. Thus the light and detail in the big picture is compressed into standard size and has complete depth of focus and no fuzziness. Wherever one sits in a cinema—right in front or at the side—there is no distortion. The demonstrations shown to the press were very well received.

Books for Young and Old

THE WHITEOAK BROTHERS, by Mazo de la Roche (*Macmillan, 12s. 6d.*).

This is the 14th novel about the life of the Whiteoak family of Jalna, but the story takes its place in the series between *Whiteoak Heritage* and *Jalna*. Followers of this lively family will welcome the filling in of this gap of the saga—the year is 1923—and the volume starts with promise as an interesting study of the adolescent boys—particularly Finch who is sketched convincingly. Readers seeking for drama and action will, however, be disappointed. Each member of the family takes as it might be a few more steps in the game, but the general picture is one of an intermediate piece rather than a vital section in the life of each generation. New readers, however, starting with this volume will certainly wish to read both on and back in this popular series.

THE WONDER WORLD OF THE SEASHORE, by Marie Neurath (*Max Parrish, 6s.*).

This slender book with its clear line drawings and bright primary colours will fascinate the child old enough to have discovered the interest of the seaside when the tide is out—with its anemones and crabs, starfish and un-named oddities. Including unusual creatures from the Atlantic coasts, it will create interest and widen horizons, suggesting the mysteries of reality. In advance of a seaside holiday—or for the inevitable rainy day—it would be a most popular and sensible present.

THE BLESSINGS OF OLD AGE (*Faber and Faber, 1s. 6d.*).

This anthology, gathered and arranged by Marjorie Eleanor Maxwell, contains well-chosen poetry and prose excerpts covering a wide range—from the Bible and the Greek philosophers to W. H. Auden and C. Day Lewis, and passing on the way, among many others, Shakespeare, John Bunyan, Blake, Shelley, Gerard Manley Hopkins, Chesterton, the Georgian poets and many examples from our own contemporaries. It is a book which would make excellent bedtime reading for the elderly, for it imparts a sense of peace and tranquillity, a soothing prelude to sleep, and would be a delightful gift for an elderly friend who is fond of poetry, whether an invalid or not.

A Patient's Crossword No. 49

Prizes will be awarded to the senders of the first two correct solutions opened on Monday, July 12. First prize 10s. 6d., second prize a book.

SOLUTIONS must reach this office not later than the first post on Monday, July 12, addressed to A Patient's Crossword No. 49, *Nursing Times*, Macmillan and Co. Ltd., St. Martin's Street, W.C.2. Write name and address in block capitals in the space provided. Enclose no other communication with your entry.

Name.....

Address.....

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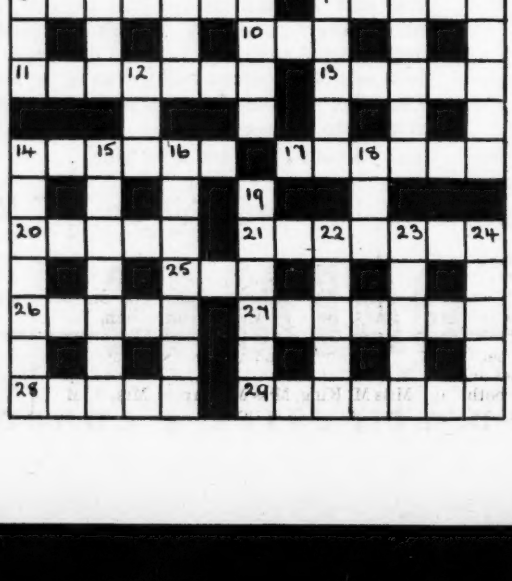

Across: 1. Decoration sounds like film star's surname (7). 5. Don't do it in the exam (7). 8. Nationality (7). 9. Farewell (5). 10. Fish (3). 11. A person given as a pledge (7). 13. Do it to your knots (5). 14. Useful tool (6). 17. A consulter (5). 20. She'll complete the puzzle! (5). 21. Jungle animal (7). 25. 'Queen ——', by Shelley (3). 26. Tasty meal or just balderdash (5). 27. Five o'clock till ten, perhaps (7). 28. '—— on the Bare Mountain': Mussorgsky (5). 29. A passing (7).

Down: 1. Circumference (5). 2. The choice for the bouquet (5). 3. Girl's name (5). 4. Describes Ginger Rogers (6). 5. Slow (7). 6. Biblical essay (7). 7. You until you're qualified—perhaps afterwards too (7). 12. '—— Sawyer' by Mark Twain (3). 14. Devonshire town (7). 15. Goes with noon and night in Vienna according to Suppé (7). 16. A pure substance (7). 18. Little devil (3). 19. Husband for a queen (6). 22. Fine music for some (5). 23. Sour substances (5). 24. Your finger (5).

The Editor cannot enter into correspondence concerning the competition and her decision is final and legally binding.

HEMPSTEAD, DR. HARVEY and a HIGHWAYMAN

Left: *the bust of Dr. William Harvey in the Harvey Chapel, St. Andrew's Church, Hempstead.*

THE small village of Hempstead, in Essex, has today at least two claims to fame. It is the birthplace of one who battened on his fellow men—Dick Turpin—and it is the burial place of one to whom mankind owes an incalculable debt—Dr. William Harvey. By his discovery of the facts of the circulation of the blood, he conferred a blessing on the human race, and immortalized his name. Yet, by a strange anomaly in human nature, for every one person who makes the pilgrimage to the shrine of Dr. Harvey, scores are attracted to the birthplace of the highwayman, at the Rose and Crown, opposite the church.

Born in 1578 at Folkestone, William Harvey was educated at King's School, Canterbury, and at Caius College, Cambridge. Thence he went to the university at Padua, taking his degree in that city famous for its teaching in a country renowned for its medical schools. Here he studied under Fabricius of Aquapendente who discovered the valves in the veins which control the one-way flow of the blood. Returning to England, Harvey established a practice in London, becoming in 1607 a fellow of the College of Physicians and later physician to St. Bartholomew's Hospital.

Appointed Lumleian lecturer to the College of Physicians in 1615, he began to develop his theories on the circulation of the blood, and first advanced his views in the following year. Servetus, the Spanish theologian and physician, had previously described the circulation of the blood through the pulmonary vessels, but it was Harvey alone who discovered that the blood circulation depended upon the muscular action of the heart.

These revolutionary views were not published until a few years later; their appearance resulted in violent criticism and even persecution, to the detriment of his private practice, in which at one time was included Sir Francis Bacon. Meantime he was appointed physician to King James I, and to King Charles I in 1632. The latter proved a helpful and constant patron, and Harvey accompanied the king through a considerable part of the Civil War, being with him at Edgehill and narrowly escaping death on at least one occasion. He followed the king to Oxford, where in 1643 he was made warden of Merton College, but in 1646 returned to London, devoting his remaining years to study.

He died in 1657, and was buried in a chapel of the church at Hempstead. In 1883 the Royal College of Physicians erected a sarcophagus in his honour, to which his remains were transferred from the vaults below. His name is further perpetuated in a statue overlooking the Channel and in the Harvey Grammar School, both at Folkestone, the school being founded by his nephew, Sir Eliab Harvey, whose descendant was in the *Fighting Téméraire* at Brest and Trafalgar. But both the Harvey chapel and the church have required, in the past, extensive repairs beyond the resources then available, and consequently proposals to transfer the remains to a more suitable resting place have been made—Canterbury Cathedral, Westminster Abbey, St. Bartholmew's, London, or Folkestone parish church having been suggested. So far there has been ecclesiastic and civil opposition from Essex, and Dr. Harvey's remains lie where they have lain for nearly 300 years. Hempstead, encouraged by a handsome contribution from the British Medical Association, feels that, in the future, it should be able to command the funds necessary for the preservation of its church.

Of the other village celebrity, Dick Turpin, so much better known to the man in the street, there is little to be said to justify his fame or the glamour clinging to his name. The romantic story of his ride to York, on Black Bess, is the creation of a 19th century novelist, Harrison Ainsworth. The facts are that Turpin's ride never occurred, Black Bess never existed, and Turpin himself was a ruffian of no more merit or attraction than the modern gangster.

Born in 1706 at the Bell Inn, now rechristened the Rose and Crown, or at an adjacent cottage, Turpin, the son of indulgent parents, spent a wild youth, during which he engaged in sheep and horse stealing. He joined a band of footpads who were terrorizing the vicinity of Epping Forest and gradually attained the leadership of the band whose activities in Essex and Surrey stimulated the authorities to offer a reward for his arrest. He was traced to a London tavern, but escaped arrest, his less fortunate companions being subsequently hanged in chains. Thenceforward he decided to work alone, and on horseback, 'practising' in the Cambridge district, but on meeting another famous highwayman, Tom King, he formed a partnership. As no roof was safe for them, they operated from a hide-out in Epping Forest, known eventually as 'Turpin's Cave'. From this coign of vantage they terrorised the district north of London, but eventually circumstances forced Tom King's brother to betray them and Tom was trapped at the Red Lion, Whitechapel. In an attempted rescue, Turpin rode up, but missing his true aim, shot King.

Turpin escaped once again, and after lying low, gradually made his way to Lincolnshire and Yorkshire, where he assumed his wife's maiden name of Palmer. His activities in this line eventually led to charges of horse-stealing, damning evidence was accumulated, and Palmer, the horse dealer, was arrested, tried, and condemned as Dick Turpin, the highwayman. He was hanged in 1739, and today you may see his fetters in the museum at York.

And if you choose, you can join the scores who visit his birthplace in the quiet little Essex village of Hempstead,, first gazing at 'Turpin's Ring'—the trees where he is said to have tethered his horse. If you do, spare a thought for Dr. Harvey, who lies in the church opposite. His work still lives.

G. E. BUNCOMBE.

Right: *the Rose and Crown, Hempstead, birthplace of Dick Turpin. The clump of trees is known as 'Turpin's Ring'; here he is said to have tethered Black Bess.*

The Midland Nursing Association of Otology

THE annual general meeting of the Midland Nursing Association of Otology was held in the Board Room of the Queen Elizabeth Hospital, Birmingham, on Saturday, May 15. The following officers were elected for the ensuing year:

President—Mr. W. Stirk Adams, senior consultant in otology, United Birmingham Hospitals; *chairman*—Miss M. Hardy, Nottingham General Hospital; *vice-chairman*—Mr. A. S. Viggars, City General Hospital, Stoke-on-Trent; *treasurer*—Miss A. Armstrong, General Hospital, Birmingham; *secretary*—Miss A. Hardiman, Public Health Department, City of Worcester.

The committee was also elected, as follows: Mrs. E. Barnfather, Mrs. R. Whittington, Miss M. King, Miss M. Perrott, Mrs. A. M. T. Cox, Miss I. N. Jameson.

Among items of business discussed was a proposed study tour to Switzerland in the spring of 1955. Following the meeting, members were entertained by Miss C. A. Smaldon, matron, Queen Elizabeth Hospital, Birmingham, and Mr. T. A. Hamilton Barnes to a delightful luncheon. An interesting clinical meeting took place in the afternoon; it included a visit to the Animal Experimental House, a talk in the physiotherapy department by Miss M. Macdonald, and a visit to the audiometric room and otological departments.

The annual dinner was held at Pattesons Restaurant, Corporation Street, Birmingham, in the evening. Members and guests enjoyed this very successful function.

The next meeting will be held on October 16 at the General Hospital, Birmingham.

XUM

SHEFFIELD REGIONAL HOSPITAL BOARD

Applications are invited for the following appointments, and should be sent, together with details of age, qualifications, training, experience and the names of two referees (or copies of two recent testimonials) To THE MATRON OF THE APPROPRIATE HOSPITAL unless otherwise stated, from whom further details may be obtained. Salaries are in accordance with the appropriate National Scales.

SOUTH YORKSHIRE

TUTORS

DONCASTER ROYAL INFIRMARY, THORNE ROAD, DONCASTER (General —330 beds). **Qualified Tutor.** Female. Post suitable for newly qualified Tutor requiring experience in teaching both senior and junior Student Nurses. Resident or non-resident.

MOORGATE GENERAL HOSPITAL, ROTHERHAM (355 beds, 38 cots). Female, S.R.N., Sister Tutor's Cert. **Unqualified applicants considered. Vacancy due to retirement.** Resident.

NETHER EDGE HOSPITAL, SHEFFIELD, 11 (Maternity Departments — 76 beds). **Midwifery Tutor.** Female. Part II Midwifery Training School. Modern department with Premature Baby Unit. Must be qualified M.T.D. Resident or non-resident.

HOME SISTER

MOORGATE GENERAL HOSPITAL, ROTHERHAM (355 beds, 38 cots). S.R.N., Housekeeping Cert. desirable, not essential. Resident.

ADMINISTRATIVE SISTERS

NETHER EDGE HOSPITAL, SHEFFIELD, 11 (459 beds). The Hospital accommodates Maternity, T.B., Chronic Sick and Rheumatism patients, with an Annexe for children's Tonsillectomy cases, and is a Training School for Assistant Nurses, Part II Midwifery and the B.T.A. Certificate. Duties will include experience in Matron's office and will generally offer good administrative training. Resident.

NIGHT CHARGE NURSE

FIR VALE INFIRMARY, SHEFFIELD, 5 (1,083 beds). To take charge of part of the Hospital only. Non-resident.

THEATRE SISTER

MONTAGU HOSPITAL, MEXBOROUGH (175 beds). **Senior Theatre Sister,** S.R.N. **Resident.**

SISTERS

DONCASTER GATE HOSPITAL, ROTHERHAM (161 beds). **Senior Sister** for Out-Patient and Casualty Depts. S.R.N., S.C.M., good casualty experience, knowledge of plaster work essential. Departmental post. Resident or non-resident.

DONCASTER ROYAL INFIRMARY, THORNE ROAD, DONCASTER (General—330 beds). **Holiday Relief Sister.** Some theatre or casualty experience an advantage. Resident or non-resident.

LODGE MOOR HOSPITAL, SHEFFIELD, 10 (508 beds). **Ward Sister,** S.R.N. (for Spinal Injury Unit). Resident or non-resident.

MONTAGU HOSPITAL, MEXBOROUGH (175 beds). **For T.B. Female Ward.** S.R.N. and preferably T.A. Certificate. Resident or non-resident.

NETHER EDGE HOSPITAL, SHEFFIELD, 11 (459 beds). **Ward Sister** for Rheumatism Research Unit. Second of two Sisters. For ward, theatre and out-patient duties. Resident or non-resident.

SANDYGATE HOUSE ANNEXE, WATH-ON-DEARNE (30 beds). **Ward Sister** S.R.N. Resident or non-resident. Applications to Matron, Montagu Hospital, Mexborough.

SWALLOWNEST I.D. HOSPITAL, SWALLOWNEST, Near SHEFFIELD (82 beds). **Ward Sister,** S.R.N., R.F.N. Resident.

STAFF NURSES

DONCASTER GATE HOSPITAL, ROTHERHAM (161 beds). **Female.** Resident or non-resident.

DONCASTER ROYAL INFIRMARY, THORNE ROAD, DONCASTER (General —330 beds). Female. For Out-Patients' Department. Also for Surgical Ward. Resident or non-resident.

MONTAGU HOSPITAL, MEXBOROUGH (175 beds). **Female,** S.R.N., for Surgical Ward, **New Unit,** and **Staff Nurse (Theatre),** S.R.N. Resident or non-resident posts.

MOORGATE GENERAL HOSPITAL, ROTHERHAM (355 beds, 38 cots). S.R.N., **Male or Female,** also **S.R.N.s, Female,** one for Theatre duties and one for Premature Baby Unit. Resident or non-resident.

NETHER EDGE HOSPITAL, SHEFFIELD, 11 (459 beds). For new Children's Tonsillectomy Unit of 19 beds. Rotating three-shift basis. Female. Resident or non-resident. Also **Male,** non-resident; **Female,** resident or non-resident; for mainly long-stay medical, but with some acute patients.

OAKWOOD HALL HOSPITAL, ROTHERHAM (T.B.—100 beds). Female, S.R.N. and/or B.T.A. Resident or non-resident.

STATE ENROLLED ASSISTANT NURSES

DONCASTER GATE HOSPITAL, ROTHERHAM (161 beds). Duty in Wards and Departments. Female. Resident or non-resident.

MONTAGU HOSPITAL, MEXBOROUGH (175 beds). Female, for **New Unit.** Resident or non-resident.

MOORGATE GENERAL HOSPITAL, ROTHERHAM (355 beds, 38 cots). **Male or Female.** Resident or non-resident.

NETHER EDGE HOSPITAL, SHEFFIELD, 11 (459 beds). For new Children's Tonsillectomy Unit of 19 beds. Rotating three-shift basis. Female. Resident or non-resident.

OAKWOOD HALL HOSPITAL, ROTHERHAM (T.B. — 100 beds). Female. Resident or non-resident.

SANDYGATE HOUSE ANNEXE, WATH-ON-DEARNE (30 beds). Female. Resident or non-resident. Applications to Matron, Montagu Hospital, Mexborough.

MIDWIFERY SISTERS

MONTAGU HOSPITAL, MEXBOROUGH (175 beds). S.R.N., S.C.M. Resident or non-resident.

MOORGATE GENERAL HOSPITAL, ROTHERHAM (355 beds, 38 cots). S.R.N., S.C.M. Required for night duties in Maternity Department. Resident or non-resident.

STAFF MIDWIVES

CITY GENERAL HOSPITAL, HERRIES ROAD, SHEFFIELD, 5 (682 beds). Post-graduate lectures arranged. Experience to be gained in all departments. Resident or non-resident.

HALLAMSHIRE MATERNITY HOME, CHAPELTOWN, Nr. SHEFFIELD (22 beds). S.R.N., S.C.M. Resident or non-resident.

SOUTH YORKSHIRE—Contd.

STAFF MIDWIVES—Continued

LISTERDALE MATERNITY HOME, WICKERSLEY, ROTHERHAM (22 beds). S.R.N., S.C.M. Resident or non-resident.

MONTAGU HOSPITAL, MEXBOROUGH (175 beds). S.R.N., S.C.M. Resident or non-resident.

MOORGATE GENERAL HOSPITAL, ROTHERHAM (355 beds, 38 cots). S.R.N., S.C.M. Resident or non-resident.

DERBYSHIRE

NIGHT SUPERINTENDENTS

BABINGTON HOSPITAL, BELPER (Chronic Sick—176 beds; Part III—132 beds; Maternity—18 beds). S.R.N., S.C.M. Resident or non-resident.

CHESTERFIELD ROYAL HOSPITAL, HOLYWELL STREET, CHESTERFIELD (257 beds). (Two Night Sisters employed also). S.R.N. Resident or non-resident.

DEPARTMENTAL SISTER

BABINGTON HOSPITAL, BELPER (Chronic Sick—176 beds; Part III—132 beds; Maternity—18 beds). S.R.N. Resident or non-resident.

NIGHT SISTERS

DERBYSHIRE ROYAL INFIRMARY, DERBY (416 beds). **Night Theatre Sister.** Resident or non-resident.

SCARSDALE HOSPITAL, CHESTERFIELD (Mainly Obstetrical, Gynaecological, Chronic Sick, and Medical—624 beds). To work under Night Superintendent, S.R.N., S.C.M. Resident or non-resident.

WALTON HOSPITAL, WHITECOTES LANE, CHESTERFIELD (Tuberculosis —146 beds). **In Sole Charge.** S.R.N. Facilities for taking B.T.A. Certificate. Resident or non-resident.

SISTERS

CHESTERFIELD ROYAL HOSPITAL, HOLYWELL STREET, CHESTERFIELD (257 beds). **Ophthalmic Ward Sister,** S.R.N. Resident or non-resident.

ETWALL HOSPITAL, ETWALL, Nr. DERBY (77 beds). **Ward Sister** for Male Ward. Resident or non-resident. Applications to Matron, Derbyshire Royal Infirmary, Derby.

CHARGE NURSE (MALE)

BABINGTON HOSPITAL, BELPER (Mainly Chronic Sick—200 beds). S.R.N. Night duty. Non-resident.

STAFF NURSES

CITY HOSPITAL, DERBY (256 beds). **Staff Nurses,** Female. **Temporary,** for busy Maternity Department. Night and day duty. S.R.N. or S.E.A.N. Five nights per week. Also for Maternity Department, day and night duty, part or full-time; S.R.N., S.C.M., or S.E.A.N.s. Resident or non-resident.

NIGHTINGALE MATERNITY HOME, PREMATURE BABY UNIT, LONDON ROAD, DERBY (18 beds). S.R.N., S.C.M. preferred. **Also Nursery Nurses,** preferably with Nursery Nurse's Diploma. Female. Resident or non-resident.

STATE ENROLLED ASSISTANT NURSES

BABINGTON HOSPITAL, BELPER (Chronic Sick—176 beds; Part III—132 beds; Maternity—18 beds). Female. Resident or non-resident.

CITY HOSPITAL, DERBY (256 beds). **Female (temporary)** for busy Midwifery Department. Night and Day duty. Resident or non-resident.

SCARSDALE HOSPITAL, CHESTERFIELD (Mainly Obstetrical, Gynaecological, Chronic Sick, and Medical—624 beds). **Male,** non-resident. **Female,** resident or non-resident.

MIDWIFERY SISTERS

ASHBOURNE MATERNITY HOME, ASHBOURNE, DERBYSHIRE (10 beds). Resident or non-resident.

CITY HOSPITAL, DERBY (256 beds). **Temporary Midwifery Sister** for at least three months' engagement. Resident or non-resident.

STAFF MIDWIVES

ASHGATE MATERNITY HOME, CHESTERFIELD (24 beds). S.R.N., S.C.M. or S.C.M. only. Resident or non-resident.

CITY HOSPITAL, DERBY (256 beds). **Staff Midwives (temporary)** for busy Midwifery Department. Night and Day duty. Resident or non-resident.

NIGHTINGALE MATERNITY HOME, LONDON ROAD, DERBY (31 beds). **Part II Midwifery Training School.** Resident or non-resident.

QUEEN MARY MATERNITY HOME, DUFFIELD ROAD, DERBY (36 beds). **Part II Midwifery Training School.** Resident or non-resident.

NOTTINGHAMSHIRE

SISTER TUTOR

VICTORIA AND KILTON HOSPITALS, WORKSOP (General — 317 beds). Resident. Applications to Matron, Victoria Hospital, Worksop.

NIGHT SUPERINTENDENTS

SHERWOOD HOSPITAL, HUCKNALL ROAD, NOTTINGHAM (Chronic and Geriatric—358 beds). S.R.N. Resident.

ADMINISTRATIVE SISTER

HARLOW WOOD ORTHOPAEDIC HOSPITAL, Nr. MANSFIELD (338 beds). Resident.

NIGHT SISTERS

HARLOW WOOD ORTHOPAEDIC HOSPITAL, Nr. MANSFIELD (338 beds). **Two Night Sisters,** under Night Superintendent. Resident or non-resident.

NOTTINGHAM CITY HOSPITAL, HUCKNALL ROAD, NOTTINGHAM (General—804 beds). Two required. To work under direction of Night Superintendent. In charge of sections. Resident or non-resident.

NOTTINGHAM HOSPITAL FOR WOMEN, PEEL STREET, NOTTINGHAM (Gynaecological and Obstetrics—153 beds). S.R.N., S.C.M. One of three. Resident or non-resident.